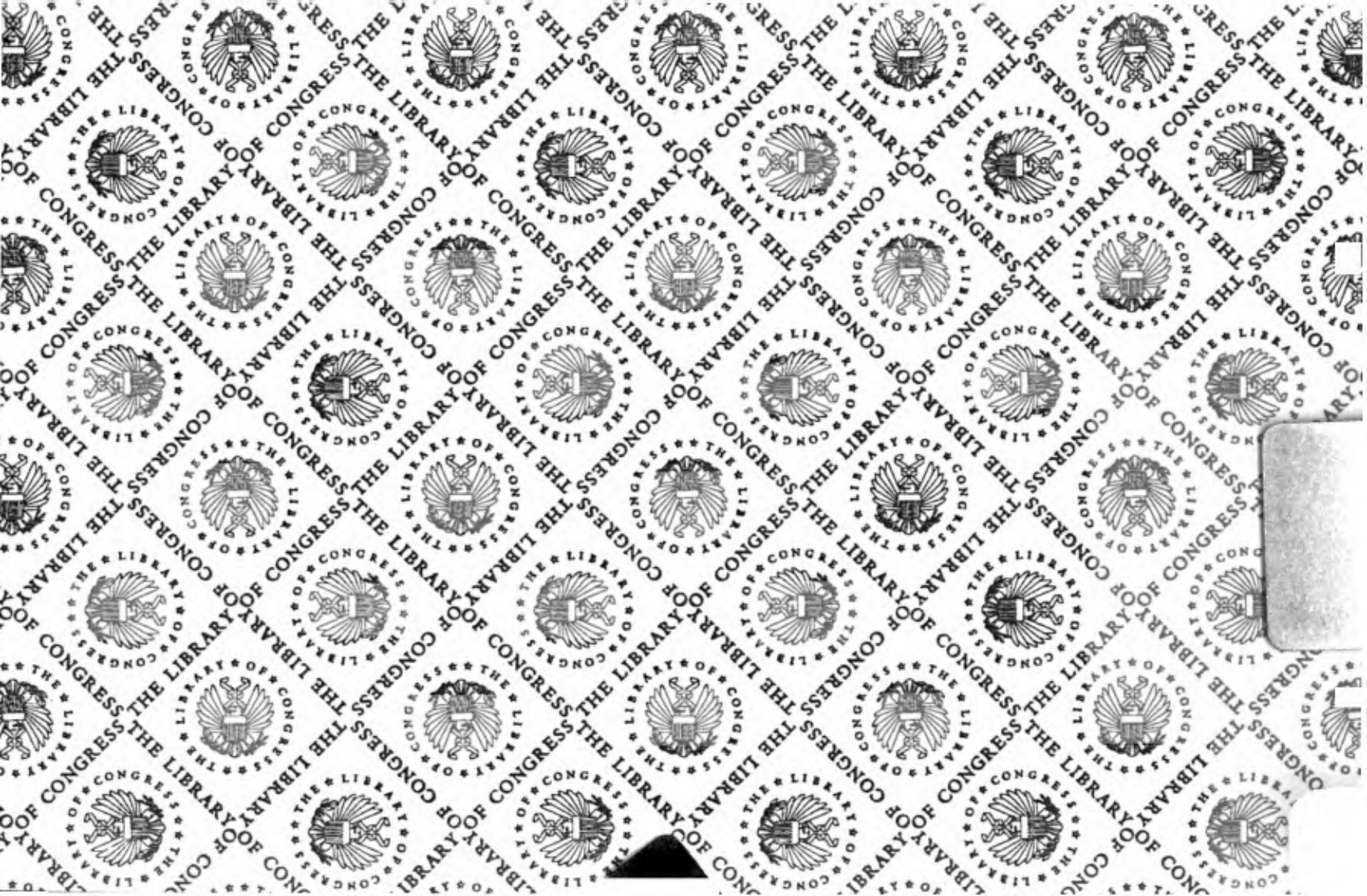
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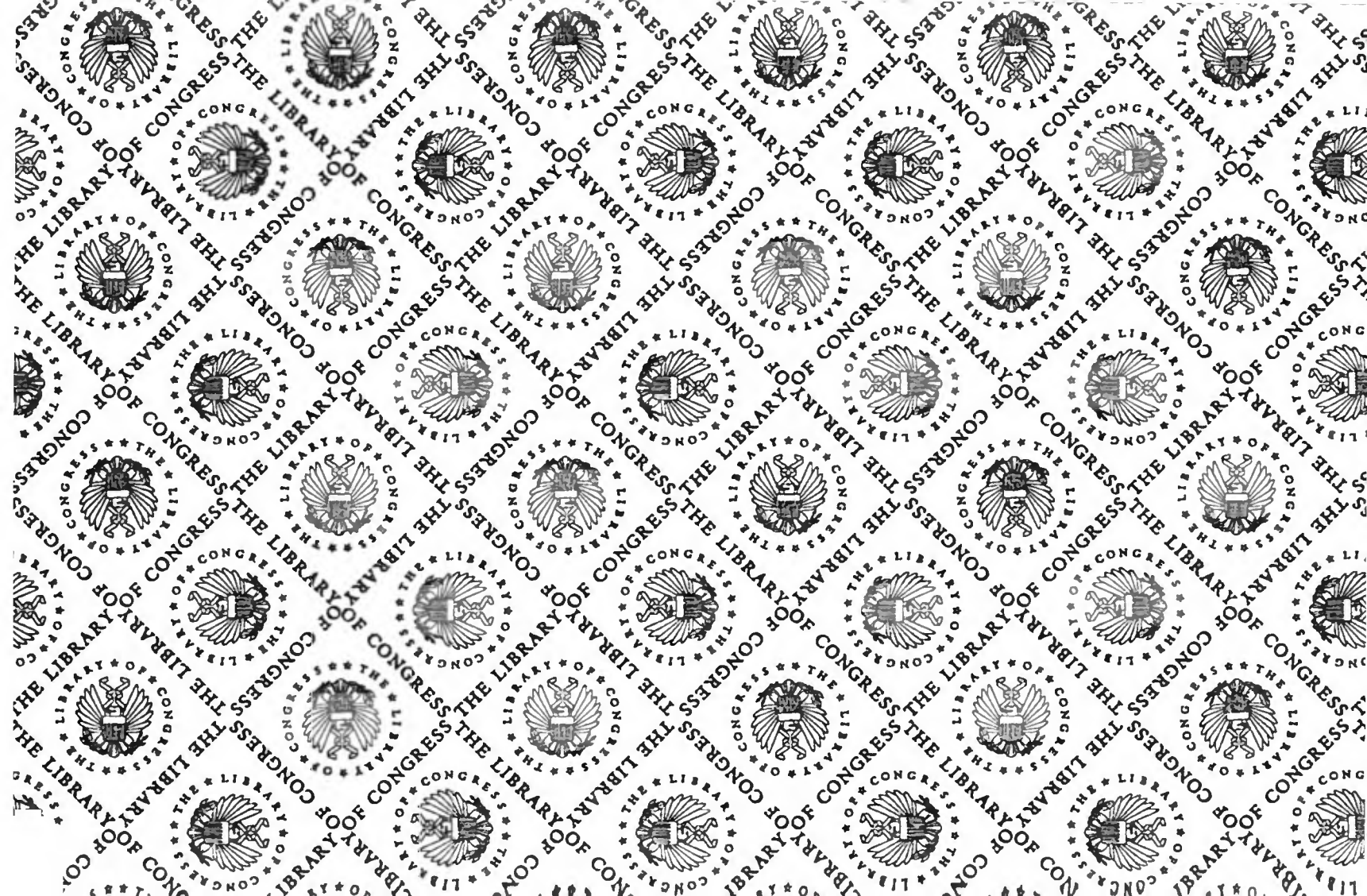
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CONTROLLED SUBSTANCES TRAFFICKING PROHIBITION ACT AND CORRECTION OFFICERS HEALTH AND SAFETY ACT OF 1997

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

ON

H.R. 3633 and H.R. 2070

MARCH 26, 1998

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CONTENTS

HEARING DATE

CONTROLLED SUBSTANCES TRAFFICKING PROHIBITION ACT AND CORRECTION OFFICERS HEALTH AND SAFETY ACT OF 1997

THURSDAY, MARCH 26, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIME
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:50 a.m., in Room 2226, Rayburn House Office Building, Hon. Bill McCollum [chairman of the subcommittee] presiding.

Present: Representatives Steve Chabot, George W. Gekas, Asa Hutchinson, Lindsey O. Graham.

Staff present: Paul J. McNulty, Chief Counsel; Glenn R. Schmitt, Counsel; Daniel J. Bryant, Counsel; Kara Norris, Staff Assistant; and David Yassky, Minority Counsel.

OPENING STATEMENT OF CHAIRMAN McCOLLUM

Mr. MCCOLLUM [presiding]. The Subcommittee on Crime will come to order.

The purpose of the first portion of today's hearing is to consider the "Controlled Substances Trafficking Prohibition Act," a bill which will soon be introduced by Congressman Steve Chabot, a member of the subcommittee. I say the first portion of the hearing because after the first three witnesses testify, we'll shift gears and consider a second bill, the "Correction Officers Health and Safety Act."

And I also want to make a point that as soon as we get a quorum, we've got a bill to markup today. So as soon as we have enough people here, Congressman Chabot, who is our first witness, will have to indulge us because we do have to proceed with that business. And from time to time during this set of hearings, I'll probably have to give the gavel to one of my colleagues because I've got to meet with the Speaker on one occasion and go to another committee on another for a brief period of time. So, whether it's Mr. Gekas or Mr. Chabot or Mr. Buyer or somebody else, I thought I would explain that to begin with.

Our first order of business is to focus on Mr. Cabot's proposed legislation and, perhaps more importantly, to examine the growing problem that this bill addresses. The magnitude of illegal drugs moving through Mexico and into the United States is dramatic, and has been well documented in recent years. An estimated 60 to 70 percent of the nearly 500 metric tons of cocaine entering the U.S.

each year enters the U.S. through Mexico. However, the problem before us today is less visible, but growing and serious. It's a very serious side of the drug problem—the rising volume of controlled substances being purchased legally in Mexico and then brought across the border into the United States. The ease with which large quantities of controlled substances can be purchased in Mexico and then legally transported into the United States has led to serious concerns among U.S. law enforcement agencies, including Customs, DEA, and the drug czar's office.

The number of Americans who regularly travel to Mexico to buy controlled substances and pharmaceutical products is astonishingly high. One study has reported that 20 percent of the U.S. residents who enter Mexico as tourists purchase pharmaceutical products while there. Another study has reported that 32 percent of the U.S. residents living along the U.S. side of the border visited a Mexican pharmacy in the previous year. And another study reported that 69 percent of the patients at an El Paso health clinic traveled to Walrus, Mexico, to purchase medications within the last month. While many of these purchases are no doubt legitimate, there is reason for concern. Many of the products in the United States that require prescription are available in Mexico as over-the-counter products.

Furthermore, certain drugs which are not legally available in the U.S., even with prescriptions, are legal in Mexico. Moreover, in Mexico, prescriptions can be written not only by physicians but also by dentists, homeopathic physicians, veterinarians, social service health care professionals, nurses, and mid-wives. This easy availability of controlled substances has led to types and quantities of products coming into the United States which raise serious questions about illegal diversion of those drugs. For example, one study found that nearly 1.5 million tablets of flunitrazepam, better known as the date-rape drug, were declared and brought into the United States in 1 year through just one gate at Laredo, Texas; 42 percent of everyone who declared drugs while coming through the Laredo, Texas crossing had to declare the date-rape drug. That the median age for those declaring the date-rape drug was only 26 illustrates further the potential abuse problems. I can elaborate but I believe my friend from Ohio, Mr. Chabot, is prepared to testify in greater detail about the problem along our border and how his proposed legislation would address it.

[The text of the bill, H.R. 3633 follows:]

105TH CONGRESS
2D SESSION

H. R. 3633

To amend the Controlled Substances Import and Export Act to place limitations on controlled substances brought into the United States from Mexico.

IN THE HOUSE OF REPRESENTATIVES

APRIL 1, 1998

Mr. CHABOT (for himself, Mr. MCCOLLUM, Mr. GEKAS, Mr. GRAHAM, Mr. HUTCHINSON, Mr. PORTMAN, Mr. BOEHNER, Mr. SESSIONS, Mr. HUNTER, and Mr. SCHUMER) introduced the following bill; which was referred to the Committee on the Judiciary, and in addition to the Committee on Commerce, for a period to be sub-

sequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Controlled Substances Import and Export Act to place limitations on controlled substances brought into the United States from Mexico.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Controlled Substances Trafficking Prohibition Act".

SEC. 2. LIMITATION.

(a) AMENDMENT.—Section 1006(a) of the Controlled Substances Import and Export Act (21 U.S.C. 956(a)) is amended by striking "The Attorney General" and inserting "(1) Except as provided in paragraph (2), the Attorney General" and by adding at the end the following:

"(2) Any individual who enters the United States through a land border with Mexico with a controlled substance (except a substance in schedule I) for which such individual does not possess a prescription written by a practitioner licensed under the authority of this Act or documentation which verifies such a prescription and who meets the requirements of paragraph (1) may bring a controlled substance (except a substance in schedule I) into the United States but only in an amount—

"(A) which is not more than 50 dosage units (as defined by the Attorney General in regulation) of the controlled substances; or

"(B) which, in the case of an individual who does not lawfully reside in the United States, is consistent with the approximate length of the individual's stay in the United States as determined by a United States Customs official at the United States border.".

(b) FEDERAL MINIMUM REQUIREMENT.—The requirement of the section 1006(a)(2) of the Controlled Substances Import and Export Act, added by the amendment made by subsection (a), is a minimum Federal requirement and does not limit any State from imposing an additional requirement.

(c) EXTENT.—The amendment made by subsection (a) shall not be construed to affect the jurisdiction of the Secretary of Health and Human Services under the Federal Food, Drug, and Cosmetic Act.

○

Unless there are other members who wish to make an opening statement, I'd like to introduce Mr. Chabot.

Our first witness today is my good friend, Congressman Steve Chabot, a member of our subcommittee. He represents the first district of Ohio and has provided outstanding service as a member of the Crime Subcommittee. He's also on the Commercial and Administrative Law Subcommittee of the Judiciary Committee, as well as the International Relations Committee of the Small Business Committee. Congressman Chabot was elected to Cincinnati's City Council in 1985. He served on the council until 1990 when he was appointed to the Hamilton County Board of Commissioners. He subsequently won election to the board in 1990 and in 1992 and served there till his election to Congress. Today, Congressman Chabot appears before us to discuss draft legislation which would prohibit trafficking controlled substances.

Congressman Chabot, Steve, welcome. Your full testimony will be entered into the record without objection. Hearing none, it's so ordered; and you may give us whatever summary you wish.

STATEMENT OF HON. STEVE CHABOT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. CHABOT. Okay. Thank you, Mr. Chairman, for holding this important hearing, and thank you for your comments. I appreciate your setting aside this time to discuss a very serious breach in our war on drugs, and I thank you for your support on my legislation.

Mr. Chairman, serious concerns have been raised by law enforcement, U.S. Customs, drug abuse prevention counselors and commissions, independent studies, and media reports about the trafficking of controlled substances from Mexico.

I would like to take a minute to make sure everyone understands what I mean when I use the term "controlled substance." Controlled substances are drugs that the Drug Enforcement Administration has either banned or subjected to closely regulated status because of their danger, addictiveness, and potential for abuse. Controlled substances include illegal drugs such as heroin and closely-regulated legal drugs such as valium.

Currently, it is particularly easy for an individual to purchase dangerous controlled substances in Mexico. These uppers, downers, hallucinogens, and date-rape drugs are obtained from so-called "health care providers" or "pharmacists" in Mexico with no documentation of medical need, then legally imported into the United States, and according to the DEA, frequently sold illegally on the streets on this Nation.

Mexican drug dealers even include detailed instructions to help American avoid arrest or drug confiscation. These instructions tell Americans such things as, "Don't use marijuana or cocaine for 2 days before" bringing the drugs into the country, "because dogs may smell." They tell them not to open the boxes in Mexico. It says, "Customs and Border Patrol don't care about medication." And, "Medication must be used only in the U.S.A., not in Mexico."

Ironically, while Mexican authorities don't mind supplying dangerous drugs to American citizens, they strictly prohibit their use in Mexico. In fact, there have been high-profile cases where U.S. citizens have been arrested for opening sealed boxes of controlled substances while still on Mexican soil.

The gaping hole in U.S. drug policy exists because of a so-called "personal use" exemption to the Controlled Substances Act that allows American drug dealers to bring in up to a 90-day supply of such drugs without a legitimate prescription or medical purpose as long as they are declared at the border. This exemption is so lax that studies along the southwest border have found records of people bringing in thousands of pills in 1 day—multiple drugs and thousands of pills in a single day for so-called "personal use."

A 1996 study published in "Clinical Therapeutics," entitled, "Pharmaceutical Products Declared by U.S. Residents on Returning to the United States from Mexico" raises serious concerns about the trafficking of controlled substances along the U.S.-Mexico border. The number and types of pills that the this particular study found at a typical board crossing back up DEA's view that these drugs are being used for illegal purposes.

This study estimated—it's called the Shepherd study—estimated that in just 1 year at the Laredo border crossing, over 60,000 drug products were brought in to the U.S. by more than 24,000 people.

All of the top 15 drug products, which represented 94 percent of the total quantity of declared drugs, were controlled substances. These dangerous drugs, classified as prescription tranquilizers, stimulants, and narcotic analgesics, are potentially addictive and subject to abuse.

Specifically, valium was declared by 70 percent of the people with the average person bring in 237 tablets. Rohypnol, commonly referred to as the date-rape drug, was brought in by 43 percent of those who declared their prescription medication. Over a full year, that means that over 4 million doses of valium and almost 1.5 million doses of Rohypnol were brought in at this single border crossing location. Further, the median age for those who declared were 24 and 26 year old, respectively.

Fortunately, Rohypnol, which is 10 times more potent than valium, has recently been banned for importation into the U.S. Unfortunately, there are hundreds of dangerous controlled substances readily available in Mexico that pose similar threats to American citizens.

This blatant perversion of our Nation's drug laws must be stopped. The personal use exemption should allow Americans who become injured or ill while traveling abroad to bring needed medicine back into the United States, but it was never intended to allow drug dealers to legally import large quantities of hazardous, mind-altering drugs into our communities.

Mr. Chairman, as you know, I have been working with Customs, DEA, and the Office of National Drug Control Policy to solve this problem. The legislation that I have proposed offers a targeted and straightforward solution to this problem.

My proposal would limit the exemption for individuals who do not possess a prescription issued by a U.S. physician or documentation which verifies a legitimate prescription. So it would actually only affect those people who do not have a prescription in this country. If they have a U.S. prescription, that's fine. An individual without this documentation would be limited to 50 dosage units of a controlled substance. The 50-dose limit would provide those people who have a legitimate need for controlled substances ample time to seek medical attention in the U.S., while virtually eliminating the abuses that are now prevalent along the U.S. border.

I want to be very clear about what this legislation does and does not do. The legislation is strictly limited to controlled substances. Again, controlled substances are drugs that the DEA has either banned or subjected to closely regulated status because of their danger, or their addictiveness, or potential for abuse. The legislation is strictly limited to those individuals that do not posses a U.S. prescription or documentation that a prescription exists. The legislation does not impact the ability of people with a prescription issued by a U.S. doctor to import any medications, including controlled substances. The legislation does not in any way change current U.S. law as it relates to the importation of prescription drugs that are not considered controlled substances. In other words, this legislation will not make it more difficult for people to obtain drugs to treat heart disease, cancer, AIDS, or other serious illnesses because these drugs are not controlled substances. In fact, none of the top 20 heart, cancer, or AIDS drugs are controlled substances.

I would also like to note that, although this problem occurs primarily along the Mexico board, it impacts communities well beyond the southwest. The study in Laredo found that residents from 39 States crossed the border and returned to the U.S. with a variety of drug products in large quantities.

Mr. Chairman, this should not be a controversial proposal. DEA and Customs identified this is a critical problem over 2 years ago. General McCaffery has written to me and expressed his belief that there is general agreement among my office, ONDCP, DEA, and Customs regarding the scope of the problem and the proposed solution.

Members of this committee recognize that prescription drug abuse is a serious problem in this country, and a growing problem particularly among our youth. The purity and the low price of prescription pills makes them an attractive alternative to street drugs.

More Americans abuse prescription drugs for non-medical purposes than us heroin, crack, and cocaine. Surprisingly, prescription painkillers, sedatives, stimulants, and tranquilizers account for 75 percent of the top 20 drugs mentioned in emergency room episodes in 1995.

Mr. Chairman, this is a very important issue that must be addressed. I appreciate your leadership and support on this issue, and I will be happy to answer any questions.

[The prepared statement of Mr. Chabot follows:]

PREPARED STATEMENT OF HON. STEVE CHABOT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Thank you, Mr. Chairman, for holding this important hearing. I appreciate your setting aside this time to discuss a serious breach in our War on Drugs, and I thank you for your support of my legislation.

Mr. Chairman, serious concerns have been raised by law enforcement, US Customs, drug abuse prevention counselors and commissions, independent studies and media reports about the trafficking of controlled substances from Mexico.

I would like to take a minute to make sure everyone understands what I mean when I use the term "controlled substance." Controlled substances are drugs that the Drug Enforcement Administration has either banned or subjected to closely regulated status because of their danger, addictiveness and potential for abuse. Controlled substances include illegal drugs such as heroin and closely-regulated legal drugs such as Valium.

Currently, it is particularly easy for an individual to purchase dangerous controlled substances in Mexico. These uppers, downers, hallucinogens, and "date-rape drugs" are obtained from so-called "health-care providers" or "pharmacists" in Mexico with no documentation of medical need; then legally imported into the United States; and, according to DEA, frequently sold illegally on the street.

Mexican drug sellers even include detailed instructions to help Americans avoid arrest or drug confiscation—these instructions tell Americans:

- "Don't use marijuana or cocaine for 2 days before because dogs may smell."
- "Don't open boxes in Mexico."
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Ironically, while Mexican authorities don't mind supplying dangerous drugs to American citizens, they strictly prohibit their use in Mexico. In fact, there have been high-profile cases where U.S. citizens have been arrested for opening sealed boxes of controlled substances while still on Mexican soil.

This gaping hole in U.S. drug policy exists because of a so-called "personal use" exemption to the Controlled Substances Act that allows American drug dealers to bring in up to a *90 day supply* of such drugs without a legitimate prescription or medical purpose, as long as they are declared at the border. This exemption is so lax that studies along the southwest border have found records of people bringing

in thousands of pills in one day—multiple drugs and thousands of pills in a single day for "personal use."

A 1996 study published in *Clinical Therapeutics*, entitled *Pharmaceutical Products Declared by US Residents on Returning to the United States from Mexico* by McKeithan and Shepherd raises serious concerns about the trafficking of controlled substances along the U.S.-Mexico border. The number and types of pills that the Shepherd study found at a typical border crossing backup DEA's view that these drugs are being used for illegal purposes.

The Shepherd study estimated that in just one year at the Laredo border crossing, over 60,000 drug products were brought in to the U.S. by more than 24,000 people. All of the top 15 drug products, which represent 94.1 percent of the total quantity of declared drugs, were controlled substances. These dangerous drugs, classified as prescription tranquilizers, stimulants, and narcotic analgesics, are potentially addictive and subject to abuse.

Specifically, Valium was declared by 70 percent of the people, with the average person bringing in 237 tablets. Rohypnol, commonly referred to as the "date-rape drug," was brought in by 43 percent of those who declared their prescription medication. Over a full year, that means that over 4 million doses of Valium and almost 1.5 million doses of Rohypnol where brought in at a *single border crossing*. Further, the median age for those who declared Valium and Rohypnol was 24 and 26 years old respectively.

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This blatant perversion of our nation's drug laws must be stopped. The personal use exemption should allow American citizens who become injured or ill while traveling abroad to bring needed medicine back into the United States—it was never intended to allow drug dealers to legally import large quantities of hazardous, mind-altering drugs into our communities.

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I would also like to note that although this problem occurs primarily along the Mexico border, it impacts communities well beyond the southwest. The study in Laredo found that residents from 39 states crossed the border and returned to the United States with a variety of drug products in large quantities.

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Members of this Committee recognize that prescription drug abuse is a serious problem in this country, and a growing problem among our youth. The purity and low price of prescription pills makes them an attractive alternative to street drugs.

More Americans abuse prescription drugs for non-medical purposes than use heroin, crack and cocaine. Surprisingly, prescription painkillers, sedatives, stimulants, and tranquilizers account for 75 percent of the top 20 drugs mentioned in emergency room episodes in 1995.

Mr. Chairman, this is a very important issue that must be addressed. I appreciate your leadership and support on this issue, and I will be happy to accept questions.

CLINICAL THERAPEUTICS®/VOL. 18, NO. 6, 1996

Pharmaceutical Products Declared by US Residents on Returning to the United States from Mexico

E. Kristin McKeithan, MS, and Marvin D. Shepherd, PhD
College of Pharmacy, University of Texas at Austin, Austin, Texas

ABSTRACT

The overall objective of this research project was to measure the types and amounts of Mexican drug products being purchased and declared to US Customs by US residents crossing the border in Laredo, Texas. Data for this study were obtained from the US Customs Declaration Form, which each person completes as he or she reenters the United States. Data included demographic information as well as the types and quantities of medications purchased. Data were collected from a randomly selected sample of 84 days between July 1994 and June 1995. A total of 5624 declaration forms were analyzed. The average age of people who declared medications was 34.5 years. Only 9.3% of the people were 50 years of age or older. Fourteen of the top 15 drug products declared are classified in the United States as "controlled" substances. In examining the quantities of medications being declared, on average 11.057 diazepam tablets were declared each day, which is equivalent to 4,035,842 diazepam tablets per year. On average 4033 tablets of flunitrazepam were declared each day, which is equivalent to 1,472,045 tablets a year declared at one US port of entry. On average, there were 2.48 drug products listed on each declaration form. The majority of the drug products were controlled substances and, based on the types and quantities of products being declared, many questions can be raised with regard to US policies on the control and safety of Mexican drugs coming into the United States.

INTRODUCTION

The extent to which US residents cross the border into Mexico to purchase pharmaceutical products has been widely publicized in the lay and academic press.[1-3]

One study has reported that 25% of the US residents who enter Mexico as tourists purchase pharmaceutical products.[4] Pharmacy owners and managers who operate pharmacies along the Texas-Mexico border have estimated that 25% of their patient clientele visit Mexican pharmacies for medications.[5] A study conducted by Families USA reported that 32% of the US residents living along the US side of the border visited a Mexican pharmacy in the previous year.[6] In addition, a 1992 study reported that 81% of the patients who visited a Texas health care clinic in El Paso traveled to Juarez, Mexico, to purchase medications. A total of 55% of these people reported that they purchase medications in Mexico several times a year, with 69% indicating that they had purchased pharmaceutical products in Mexico within the last month.[7]

The reported main reasons why US residents travel to Mexico to purchase pharmaceutical products are lower drug prices when compared with the US pharmaceutical market and easier access to prescription drug products.[6] The lower drug costs and easy access make Mexican medications very attractive to US residents who have chronic diseases that require expensive medications. Thus the elderly, retirees who are living on fixed incomes, and others who are interested in saving money see the lower-priced Mexican drugs as a relief from the expensive US health care system.[6,8]

The single most common reason US residents visit Mexico to acquire pharmaceutical products is the low prices of Mexican medications. Mexico's National Health Care System controls the price of pharmaceuticals. Retail pharmacies can lower their selling price as much as 20% below the government ceiling price but cannot raise their price above the ceiling price. In the marketplace, it is not uncommon for customers to haggle with pharmacists or pharmacy employees about the price of medications.

The second major reason US residents visit Mexico to purchase prescription medication is the easy access. Major differences exist between the United States and Mexico in how drug products are regulated and distributed. Many of the products referred to as "legend" drug products in the United States—those products that require a prescription—are readily available as over-the-counter drug products in Mexico and require no prescription. Pharmaceutical products that have the potential for abuse or are dangerous to use and need supervision from a health care practitioner require a prescription. These products are primarily narcotics and psychotropic medications. Prescriptions in Mexico can be written by physicians, dentists, homeopathic physicians, veterinarians, health professionals in the social services, nurses, and midwives.[9] Although a prescription is required by law, it is not uncommon to obtain pharmaceutical products from retail pharmacies in Mexico without a prescription.[7,9] Furthermore, obtaining a prescription for these regulated products is not difficult in Mexico.[10]

The literature is weak in documenting the types and amounts of pharmaceutical products US residents purchase in Mexico. Most studies have concentrated on the activity of US residents living along the US-Mexico border. However, it is unknown to what extent nonborder US residents patronize Mexican pharmacies. After spending an afternoon with US Customs officials in Laredo, Texas, and visiting pharmacies in Nuevo Laredo, Mexico, we realized that quantities of Mexican drug products being brought

from Mexico into the United States were greater than anticipated. We also realized that the situation did not just apply to the Texas border area. US residents from many states were crossing the border in Laredo and returning to the United States with a variety of drug products in large quantities.

The overall objective of this research project was to document the types and amounts of Mexican drug products that were declared by US residents at the US Customs border crossing in Laredo, Texas. Other objectives for this project were to determine the demographic profile of US residents who have declared pharmaceutical products and to determine the number of people declaring such products who are from Texas and from other states.

SUBJECTS AND METHODS

The data used in this study were collected from the US Customs Declaration Form 6059B(013194) at the Laredo US Customs border crossing, Bridge One. Bridge One handles visitor travel by foot and automobile but not commercial travel such as large trucks or tractor trailer vehicles. The procedure for reentering the United States through Customs consists of Customs officials questioning visitors to Mexico about their citizenship status and randomly inquiring about any purchases made in Mexico. If one of the purchases includes medications, the tourists are instructed to complete a declaration form. The declaration forms are signed, dated, and turned over to Customs officials. Customs agents visually inspect all medications purchased to make sure the form was completed accurately.

Declaration information was collected over a randomly selected number of days for 12 months. One Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, and Sunday for each month between July 1994 and June 1995 was randomly selected, resulting in a sample of 84 days. The reason for this method of selecting days was to control for any effects of seasonality, day of the week, or time of the month.

The variables collected from the US Customs Declaration Form included date of the claim, state of residence, country of citizenship and residence, value of each product purchased and total value of all goods purchased in Mexico, names of drugs, and the number of packages purchased. The person's sex was inferred from his or her name. The day of the week was translated from the date of the claim. Names of the individuals who completed the declaration forms were not collected and thus were not included in the database. In addition, names of the Customs officials who supervised the declaration process were not included in the database.

Many of the pharmaceutical products purchased in Mexico have different names than those used in the United States, and many products are not available in the United States. Mexico's version of the *Physicians' Desk Reference*®, *Diccionario de Especialidades Farmaceuticas*, was used to identify drug products and determine drug therapeutic categories.[11] Mexican pharmaceutical products are packaged and sold in preset quantities per package per container. This same reference book contains information on product packaging and was used to determine the number of tablets, capsules, or ampules per package of the drug listed on the declaration form. In most instances, drug strengths were not listed on the declaration forms; thus all products of the same

name were grouped together regardless of the dose strength.

RESULTS

Demographic Description of Sample

During the 84 days sampled, a total of 5624 declaration forms were submitted. Men completed 3391 (60.3%) forms, and women completed 2178 (38.7%) forms. The sex of the person declaring the pharmaceutical products could not be identified for 55 (1.0%) forms. The average age of people who declared medications was 34.5 ± 10.7 years. On average, the men were younger than the women (33.2 years vs 34.8 years). The median age was 33 years for men and 35 years for women. People older than 50 years only represented 9.3% of the sample. People younger than 40 years represented more than 50% of the people declaring drug products. Overall, an average of 67 people declared pharmaceutical products per day.

Geographic Distribution of People

A total of 39 states were listed as the state of residence on the declaration form. People who resided in Texas accounted for 63.9% (n = 3595) of the total. Louisiana and Oklahoma ranked second and third highest in the number of people declaring drug products. A total of 15.4% (n = 867) of the people were from Louisiana and 8.0% (n = 453) were from Oklahoma. People declaring medications came from as far away as Alaska, Washington, Minnesota, Massachusetts, and Florida. All geographic regions of the country were represented; nearly 40% of the people making declarations were not residents of Texas.

Types and Quantities of Pharmaceutical Products Declared

The 5624 declaration forms contained 13,959 drug product entries. These entries represented 112 different drug products in 36 therapeutic classes. The average number of drug products declared per day was 166.2. Extrapolating to a full year, we estimated that 60,663 drug products were declared at the Laredo border crossing by 24,455 people during the study's 12-month time frame (166.2 drug product entries per day × 365 days, and 67 people per day × 365 days). An average of 2.48 drug products were listed on each declaration form.

The top 15 drug products, by number of people declaring the product and the total units declared, are listed in Table I. These top 15 drug products represent 94.1% (n = 13,142) of all drugs listed on the declaration forms. Diazepam (Valium®, Productos Roche, S.A. de C.V., Benito Juarez, Mexico), the drug listed most frequently on the declaration forms, was declared by 69.8% (n = 3923) of the people making drug declarations. The average number of diazepam tablets declared was 236.8 tablets per person. Diazepam was followed by another benzodiazepine product, flunitrazepam (Rohypnol®, Productos Roche, S.A. de C.V., Benito Juarez, Mexico). Flunitrazepam was brought into the United States by 42.5% (n = 2393) of the people. The average number of tablets declared per person was 141.6. Third on the list was an anxiolytic product, alprazolam (Tafil®, Upjohn, S.A. de C.V., Coyoacan, Mexico), with 23.4% (n = 1316) of the people declaring this product. Fourth on the list was a stimulant product used for weight reduction called diethylpropion (Tenuate Dospan®, Laboratorios Lepetit de Mexico,

Table I. Top 15 pharmaceutical products ranked by number of people declaring the product and total quantity declared.

Rank and Drug Product (therapeutic class)	Mexican Brand Name	Total No. of People* (% of all declarations)	Total No. of Units (tablets, capsules)
1. Diazepam (benzodiazepine)	Valium (Productos Roche, S.A. de C.V., Benito Juarez, Mexico)	3923 (69.8%)	928,800
2. Flunitrazepam (benzodiazepine)	Rohypnol (Productos Roche, S.A. de C.V.)	2393 (42.5%)	338,760
3. Alprazolam (benzodiazepine)	Tafil (Upjohn, S.A. de C.V., Benito Juarez, Mexico)	1316 (23.4%)	284,130
4. Diethylpropion (stimulant)	Tenuate Dospan (Laboratorios Lepetit de Mexico, S.A. de C.V., Morelos, Mexico)	1013 (18.0%)	111,060
5. Oxycodone (narcotic analgesic)	Neopercodan (Rhône-Poulenc Rorer, S.A. de C.V., Benito Juarez, Mexico)	862 (15.3%)	42,550
6. Phentermine (stimulant)	Diminex (Pharma de Mexico, S.A. de C.V., Mexico City, Mexico)	849 (15.1%)	79,140
7. Clobenzorex (stimulant)	Asenlix (Grupo Roussel, S.A. de C.V., Coyoacan, Mexico)	596 (10.6%)	92,760
8. Codeine/APAP (narcotic analgesic)	Tylex (Cilag de Mexico, S.A. de C.V., Coyoacan, Mexico)	503 (8.9%)	16,230
9. Propoxyphene (narcotic analgesic)	Darvon (Eli Lilly y Compania de Mexico, S.A. de C.V., Coyoacan, Mexico)	467 (8.3%)	37,940
10. Nalbuphine (injectable narcotic analgesic)	Nubain (Rhône-Poulenc Rorer)	362 (6.4%)	1,810
11. Diazepam/APAP/propoxyphene (benzodiazepine)	Qual (Laboratorios Silanes, S.A. de C.V., Benito Juarez, Mexico)	227 (4.0%)	13,800
12. Triazolam (benzodiazepine)	Halcion (Upjohn, S.A. de C.V.)	217 (3.9%)	16,470
13. Methylphenidate (stimulant)	Ritalin (Ciba-Geigy Mexicana, S.A. de C.V., Coyoacan, Mexico)	159 (2.8%)	13,380
14. Lorazepam (benzodiazepine)	Ativan (Wyeth, S.A. de C.V., Mexico City, Mexico)	145 (2.6%)	15,000
15. Carisoprodol/ibuprofen (muscle relaxant)	Somalgesic (Warner Wallace, S.A., Miguel Hidalgo, Mexico)	110 (2.0%)	10,880

[illegible]

[illegible]

S.A. de C.V., Morelos, Mexico), and the fifth product was oxycodone (Neopercodan®, Rhône-Poulenc Rorer, Benito Juarez, Mexico), a narcotic analgesic.

In looking at the remaining 10 products, one sees a similar trend in therapeutic categories. All products were narcotic analgesics, stimulants, or benzodiazepines, with the exception of one muscle relaxant. All of the top 15 products, which are available in the United States, are classified as "controlled substances" in this country. The products in the top 15 not available in the United States are flunitrazepam, clobenzorex (Asenlix®, Grupo Roussel, S.A. de C.V., Coyoacan, Mexico), diazepam/acetaminophen/propoxyphene combination (Qual®, Laboratorios Silanes, S.A. de C.V., Benito Juarez, Mexico), and carisoprodol/naproxen (Somalgesic®, Carter Wallace, S.A., Miguel Hidalgo, Mexico).

In just the 84 days sampled, close to 1 million tablets of diazepam were declared. On average, 11,057 tablets were declared per day. This is equivalent to 4,035,842 diazepam tablets declared and brought into the United States each year at one port of entry. For flunitrazepam, an average of 4033 tablets were declared per day, which is equivalent to approximately 1,472,045 tablets per year that were declared and brought into the United States through Laredo during the study period. In addition, 1,234,613 tablets of alprazolam were declared.

Because different products are supplied in different quantities per package, an analysis by number of drug packages or

Table II. Top 15 pharmaceutical products and total number of drug packages declared, mean number of packages per person, range in the number of packages declared per person, and package size.

Rank and Drug Product	Total No. of Packages	Mean No. of Packages per Person*	Range in No. of Packages per Person	No. of Units per Package
1. Diazepam	10,320	2.5	1–25	90
2. Flunitrazepam	11,292	4.6	1–18	30
3. Alprazolam	3157	2.4	1–16	90
4. Diethylpropion	3702	3.6	1–23	30
5. Oxycodone	4255	4.9	1–29	10
6. Phentermine	2638	3.4	1–30	30
7. Clobenorex	1546	2.6	1–15	60
8. Codeine/APAP	1623	3.2	1–12	10
9. Propoxyphene	1546	2.6	1–15	60
10. Nalbuphine	1447	4.0	1–15	5
11. Diazepam/APAP/propoxyphene	690	3.0	1–10	20
12. Triazolam	549	2.5	1–10	30
13. Methylphenidate	446	2.8	1–6	30
14. Lorazepam	375	2.6	1–12	40
15. Carisoprodol/naproxen	363	3.3	1–17	30

*APAP = acetaminophen

*Mean number of drug packages per person = total number of drug packages ÷ number of people declaring the drug

containers was conducted (Table II). The most striking observations in Table II are the average number of packages per person and the range in number of packages declared. For example, the average number of drug packages declared per person for diazepam was 2.5, but at least one person declared 25 packages of diazepam. In other words, the person who declared 25 packages brought 2250 tablets of diazepam into the United States. Another person declared 18 packages of flunitrazepam, which contained 540 tablets.

DISCUSSION

The results of this research show a vast difference in the pharmaceutical product mix purchased and declared by US residents than was expected or even reported by the lay press or academic literature. The press has pointed out that many elderly and others who cannot afford US drug products frequently travel to Mexico to purchase medications for their ailments. However, the demographic profile of people declaring drugs at Bridge One in Laredo does not fit the description of the elderly, and the top 15 drug products do not fit the scenario of drugs for disease conditions commonly found in the elderly, such as hypertension, cardiovascular disease, or diabetes.

The results of this exploratory study show that a large quantity of controlled substances are coming across the border into the United States from Mexico. Some of these products may be for a legitimate use, such as the treatment and care of a disease condition. However, the types and quantities of products coming through US customs raise some serious questions about this assumption. For example, nearly 1/3 of the people declaring drugs declared diazepam, a benzodiazepine drug product, and more than 42% declared flunitrazepam, a product involved in a growing and serious problem of abuse in the United States. The legitimate use for flunitrazepam in Mexico is to treat severe insomnia, and it is used as a preanesthetic medication. Furthermore, the median ages for people declaring diazepam and flunitrazepam were 24 and 26 years, respectively. The researchers question the legitimate needs of hundreds of 20 year olds for diazepam and flunitrazepam. In addition, 1858 (33.0%) of the people in the data set declared at least one package of diazepam together with at least one package of flunitrazepam. The next section describing flunitrazepam explains the dangers of taking these two products in combination.

Flunitrazepam is gaining in popularity as a drug of abuse in the United States.[12] The lay press has reported that flunitrazepam is becoming the "culture" drug of the 1990s. It is a popular street drug, and sells for as much as $5.00 a tablet in some regions.[13] The street names for flunitrazepam are "roofies," "rope," "ropies," "roach," "the forget pill," "Mexican Valium," "roopies," "roach-2," "R-2" and "ruffies." It can be purchased in Mexico for about $0.50 a tablet. It causes a "drunken stupor" and has been reported "to have more intoxicating power than a six-pack of beer."[14] It has been estimated to be 10 times stronger than diazepam.[12] Furthermore, it has been reported to cause complete short-term amnesia, thus the name "the forget pill." It is extremely dangerous when mixed with alcohol and has been implicated in date rape cases.[15]

Flunitrazepam abuse has drawn so much attention that on March 5, 1996, the US Treasury Department decided to ban

US residents from bringing flunitrazepam into the United States.[16] Furthermore, on October 13, 1996, President Clinton signed legislation that makes it a crime to use a drug product as a weapon and adds 20 years to the sentence for rapists who subdue victims with "date rape drugs." This bill was a direct reaction to the increased abuse of flunitrazepam.

US Customs' requirements for bringing medications into the United States are that only a "reasonable" amount of medication can enter the United States, and that the medications are for personal use. US Customs port in Laredo has defined a "reasonable" amount of medication as a 90-day supply. However, each US Customs port of entry defines "reasonable" amount differently. All medicinal agents must be properly identified, and the person must have either a prescription or written statement from a physician stating that the medicines are being used under a physician's directions and are necessary for physical well-being.[17]

Furthermore, although US Customs allows the person to bring Mexican pharmaceuticals into the United States, the person may still be in violation of state and federal rules and regulations for prescription and controlled drug products. For example, in Texas, US residents returning from Mexico with controlled substances are in violation of the Texas and federal controlled substance regulations, because Mexican prescriptions for controlled substances are not valid in Texas unless the prescriber is licensed in Texas and is registered with the US Drug Enforcement Administration (DEA). Currently, there are no physicians in Mexico with a DEA registration. Second, the vast majority of drug products from Mexico are not properly labeled; thus they do not conform with the Controlled Substance Act of 1970. Few medicinal products from Mexico have patient-specific drug labels. Finally, the drug product is in violation of federal law, because currently none of the products coming from Mexico are approved by the US Food and Drug Administration. Thus persons carrying controlled substances from Mexico are in possession of an illegal controlled substance and are subject to arrest.

Limitations

The prime limitation of this research was that the results of this study cannot be extrapolated to other border crossings in Texas or along the southwest border of the United States. No other ports of entry along the Texas-Mexico border use the declaration form for medications purchased in Mexico. Another limitation is the likely underestimation of the quantities of drug products being purchased in Mexico. This study concentrated on drug products that were declared. The drug quantities measured were purchased in Mexico, but the declarations do not represent purchases made by people who did not complete declaration forms or people who smuggled drug products into the United States. Medications seized by US Customs were also not included in this study. US Customs officials seize all medication if the quantity declared is not reasonable, the product is banned in the United States, or the person is discovered trying to smuggle drugs into the United States without making a declaration.

CONCLUSIONS

When work on this project began, we believed that the most frequent drug prod-

ucts declared would be antibiotics and drugs for the treatment of chronic health conditions such as cardiovascular problems, arthritis, diabetes, and lipid management problems. However, this assumption was not supported by the research. The results of this study do not refute the possibility that many US residents travel to Mexico to purchase medications for the treatment of chronic health conditions. The results did show, however, that if people frequently travel to Mexico to obtain their chronic medications, they certainly are not declaring these products at the US Customs office in Laredo on their return to this country. A different research methodology and approach are needed to document the extent to which people are purchasing chronic medications in Mexico and returning to the United States through Laredo. Perhaps conducting this research project at a different US port of entry would have produced different results.

Even though the results were much different from what was anticipated, the findings do not diminish the importance of this study. The study's results highlight perhaps a much larger US health, social, economic, and policy problem than the one originally hypothesized.

ACKNOWLEDGMENTS

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

January 27, 1998

Dear Representative Chabot:

Thank you for your letter dated November 10, 1997, on the importation of prescription drugs from Mexico. You have appropriately highlighted a situation with significant potential for abuse.

As you know, representatives from ONDCP, DEA, and Customs met with your staff on January 8 to discuss this issue and the specific questions you posed in your letter. There was general agreement regarding the scope of the problem, the status of current law, and the proposed solution. ONDCP staff will continue to monitor progress in addressing this problem and will keep your office informed of developments.

We appreciate your bringing this to our attention and look forward to working with you.

Respectfully,

Barry R. McCaffrey
Director

The Honorable Steve Chabot
United States House of Representatives
Washington, D.C. 20510

Mr. MCCOLLUM. Thank you very much, Mr. Chabot. I'll give myself a little time, as I do have a couple of questions. How might this legislation affect those individuals, Steve, particularly the elderly and economically disadvantaged, who buy drugs in Mexico primarily because of economic reasons—because they're cheaper than they are here in the U.S.?

Mr. CHABOT. That's a very good question, Mr. Chairman. There really should not be any concern about the ability of American citizens to obtain cheaper drugs in Mexico. This legislation is aimed at controlled substances, which principally consist of mind-altering drugs and stimulants and downers. This proposal does not touch prescription drugs like antibiotics and cancer medication, because those drugs, again, are not controlled substances. In fact, none of the 20 most prescribed drugs for heart ailments and cancer and AIDS—I've mentioned in my testimony—are controlled substances, meaning that this legislation would not affect a person's ability to get these drugs for a lower cost in Mexico.

There have also been a number of studies of the people who go to Mexico and get prescription medication and—as you mentioned in your testimony as I followed up in mine—they tend to be young—the average is 24 to 26 years old, so it shouldn't affect elderly people. It shouldn't affect low-income people who have a legitimate reason to try to obtain drugs. And finally, this legislation will not affect the U.S. citizen's ability to obtain a controlled substance from Mexico as long as they possessed a U.S. doctor's prescription.

I think that it's a reasonable requirement that the DEA has classified these substances as controlled substances because they should be used under a doctor's supervision. And we want to encourage, certainly, people who are going to use these dangerous drugs to obtain professional medical advice. We don't want people to, in effect, to prescribe their own doses and use their own controlled substances.

Mr. MCCOLLUM. Why can't Customs or another Federal agency do the job without the need for this legislation?

Mr. CHABOT. Well, theoretically—you know, they could. The DEA could—they could, for example, change its regulations to clearly restrict the ability of pushers to bring these dangerous controlled substances into the U.S. from Mexico. However, the Federal Government is not always the most efficient when it comes to changing long-standing policy. And this situation appears no different.

In fact, the U.S. Customs service raised this concern in a letter to General McCaffery way back in August 1996. And although I'd like to thank the General McCaffery—I want to thank him for his cooperation with my office on this issue, the ONDCP and DEA were unable to move a solution to this problem through the Federal bureaucracy. In discussions with the DEA and Customs and the ONDCP about possible solutions to this problem, I was informed that a regulatory solution could take 2 years to enact or longer. And I believe that that's too long to leave our children vulnerable to the danger that these drugs pose.

Mr. MCCOLLUM. Thank you. Mr. Gekas?

Mr. GEKAS. Yes, thank you, Mr. Chairman. Steve, I have to tell you this is one of finest examples throughout my experience in the

Congress of crafting legislation to meet a stated problem head-on. I commend you on it, and I want to help you take it as far as it can go, right to the President's desk.

Mr. CHABOT. Thank you very much.

Mr. GEKAS. One question—it may be a dumb question—I read over the article that you submitted with your testimony from—who is it? Dr. McKeithan or Shepherd, is it with a PhD?

Mr. CHABOT. Yes.

Mr. GEKAS. On the overall problem which you have described. Nowhere in your statement, and in your presentation, or in this, is there any mention of—and maybe there is no need to—of NAFTA. In other words, did this—did the question of pharmaceuticals—because I remember that during the battle on NAFTA, pharmaceuticals was a part of the overall categorization of items that were going to subjected to the trade agreement. But I saw no—nothing here that impacted on NAFTA or that NAFTA impacted. Does that—?

Mr. CHABOT. Yeah, I'm not—that's a good question. I'm not sure if NAFTA really had any impact on the increasing drugs coming into the country or the regulations that would be involved in that. We do have several other witnesses following myself who might have the answer to that questions, Mr. Gekas.

Mr. GEKAS. Very good, we'll ask it. One other thing, in answer to the question posed by the chairman and an additional answer, is it not so that—that in considering the plight of those who can't afford normal costs of pharmaceuticals in the U.S. tempting them to go to Mexico, you're limited them to 50 units. Doesn't that, most of the time, cover those who are trying to seek pharmaceuticals at a lower cost?

Mr. CHABOT. Sure, it certainly should, and in addition, we're only talking about controlled substances here.

Mr. GEKAS. Yes.

Mr. CHABOT. And if they have a—if they have U.S. prescription, then they are not affected in any event. As long as they have a doctor's prescription from the United States. This only really affects those people who would come into this country without a U.S. prescription; so that's what the problem has been. People that go over to Mexico to get Rohypnol for the date-rape type drug, for example, or valium; and they go to one of these pharmacists over there—and we also are going to have a tape in a little while that's going to be shown where you can see first-hand what actually happens over there. And that's the real problem; not the senior who wants to go over to Mexico and has a prescription to save some money, that's fine. We're all for folks that have legitimate reason to be over there purchasing their drugs being allowed to do that.

Mr. GEKAS. I thank you. I'm very much enthused about the prospects of this legislation. And I yield back the balance of my time.

Mr. CHABOT. Thank you, Mr. Gekas.

Mr. MCCOLLUM. Mr. Hutchinson, you're recognized if you wish to ask Mr. Chabot some questions.

HUTCHINSON. Thank you, Mr. Chairman. I just want to express my thanks to Mr. Chabot for taking leadership on this issues. Particularly I'm concerned about the drug Rohypnol. In Arkansas, we have had two extraordinary cases where this drug has been used.

And, luckily, the prosecutions were successful because there was actually a tape of the victim being assaulted by the perpetrator, and that tape was used in order make the prosection, otherwise, because Rohypnol—you know—preys upon a victim and makes their memory faulty. You can't even make a prosecution. And, of course, this drug comes from Mexico.

Mr. CHABOT. Right.

Mr. HUTCHINSON. And it is not even lawful in the United States. And so this addresses a problem that touches upon my State and I'm delighted that you're taking leadership in this. And I yield back the balance of my time.

Mr. CHABOT. Thank you. And if I could just follow up a real quick comment. Valium was the number one drug being brought into the country this way and Rohypnol was number two. So they are—clearly it's a drug of abuse, and particularly for predators who would prey on women, it's a drug that's used. And this is an opportunity to stop that from happening.

Mr. MCCOLLUM. Thank you, Mr. Hutchinson.

Mr. Graham, do you have any questions of the witness?

Mr. GRAHAM. Just basically to say thank you for addressing the problem. I think it scares the heck out of a lot of people, Steve. And I know this—I've seen on several television shows about going to Mexico and doing what you're trying to control a bit. But not really, I'm ready to vote.

Mr. MCCOLLUM. Well, we're about to do that. [Laughter.]

Mr. MCCOLLUM [continuing]. Before we do that, I want to welcome you this morning. I think this is the first Subcommittee on Crime hearing since you've been a member of the committee. So, that's a good introduction; a good way to go. With that in mind then, Mr. Chabot, we thank you. We'll excuse you as a witness.

Mr. CHABOT. Thank you.

Mr. MCCOLLUM. The proceeding on this bill will be recessed pending the taking up of the bill that we have for mark-up today. We'll come back to the hearing.

[Whereupon, at 10:11 a.m., the subcommittee proceeded to other business.]

Mr. MCCOLLUM. I will introduce our second panel and ask them to come forward. Our first witness on the second panel is Mr. Matt Meagher. Mr. Meagher is a senior investigative reporter at Inside Edition. His previous work at Inside Edition includes exposes on kickback scams of Medicare providers and on the disturbing rise of teen gambling in our Nation's high schools. Prior to joining Inside Edition, Mr. Meagher headed the investigative units at several local television stations in St. Louis and Boston. Among the numerous awards Mr. Meagher has received for his reporting are eight Emmys, an Alfred I. Dupont Award, and the prestigious George Polk Award.

Welcome, Mr. Meagher. We're glad to have you with us.

Also appearing before the subcommittee today is Mr. Wesley Windle. Mr. Windle is a program officer in the U.S. Customs Service. He is currently assigned to the Office of Field Operations and Customs Passenger Operations Division. He transferred to this position at headquarters 2 years ago. Prior to that transfer, he was an instructor for the U.S. Customs Service at the Federal Law En-

forcement Training Center in Glynco, Georgia. Mr. Windle's experience with Customs has been augmented by his work in the Contraband Enforcement Team and domestic and international outreach programs. We welcome you, Mr. Windle, as well.

I understand that the Customs Service has been quite helpful to Mr. Chabot's office as they've worked on this proposed bill which we appreciate a great deal.

Both of your full statements will be admitted into the record, without objection. We will be glad to hear a summary of your testimony at this time.

Mr. Meagher, please proceed.

Mr. MEAGHER. If I could show a quick tape.

Mr. MCCOLLUM. Sure.

[Video presentation.]

Mr. CHABOT [presiding]. Thank you. Thank you very much for showing the tape. I thought the Congressman's comments on your tape were particularly articulate——[Laughter.]

Mr. CHABOT [continuing]. But [Laughter.]

Mr. CHABOT [continuing]. But we do very much appreciate you being here and the chairman already having introduced you, we'll go straight to your testimony.

STATEMENT OF MATT MEAGHER, SENIOR INVESTIGATIVE REPORTER, INSIDE EDITION

Mr. MEAGHER. Thank you, Mr. Chairman, members of the committee, thank you for inviting me. As a journalist, I'm not in the habit of appearing before Congressional committees to testify. I'm not here to lobby for any legislation or to even give an opinion about legislation, but because of the importance of this issue, I do welcome the chance to have the subcommittee see our broadcast that exposed the dangers that we found in Mexico.

We went to Mexico to investigate what we later called the Mexican pill popline—"the Mexican pill pipeline." It's a pipeline that invites drug abuse. Until you go there, it's hard to believe just how easy it is for anyone, especially young people, to buy any prescription pill they want.

As you saw in our report, we visited numerous doctors' offices and pharmacies. As our broadcast makes clear, not once were we ever asked a single question about our health or medical condition. The doctors and pharmacists only wanted to know which drugs we wanted and how much.

The "Mexican pill pipeline" not only invites drug abuse but also poses a real threat to women. The Texas Commission on Alcohol and Drug Abuse has told us kids were going to Mexico to get date-rape drugs; so we specifically asked for date-rape drugs. These so-called doctors were not shocked. They didn't criticize us. They told us what drugs to buy and how to use them.

In sort, we have the perfect formula for prescription drug abuse. The drugs are cheap, they're easy to get, and it's perfectly legal to bring them back into this country.

In broadcasting this report, it was Inside Edition's hope that we could help bring this problem to the Nation's attention. I appreciate the opportunity to bring this broadcast to the attention of this subcommittee.

Thank you.

[The prepared statement of Mr. Meagher follows:]

PREPARED STATEMENT OF MATT MEAGHER, SENIOR INVESTIGATIVE REPORTER, INSIDE EDITION

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We went to Mexico to investigate what we later called the "Mexican Pill Pipeline." It's a pipeline that invites drug abuse.

Until you go there, it's hard to believe just how easy it is for anyone, especially young people, to buy any prescription pill they want. As you saw in our report, we visited numerous doctors' offices and pharmacies. As our broadcast makes clear, not once were we ever asked a single question about our health or medical condition. The doctors and pharmacists only wanted to know which drugs we wanted and how much.

The "Mexican Pill Pipeline" not only invites drug abuse but also poses a threat to women.

The Texas Commission on Alcohol and Drug Abuse had told us kids were going to Mexico to get date-rape drugs. So we specifically asked for date-rape drugs. These so-called doctors were not shocked. They didn't criticize us. They told us what drugs to buy and how to use them.

In short, we have the perfect formula for prescription drug abuse. The drugs are cheap, they are easy to get, and it's perfectly legal to bring them into the country.

In broadcasting this report it was Inside Edition's hope that we could bring this problem to the nation's attention. I appreciate the opportunity to bring this broadcast to the attention of this subcommittee.

Thank you.

Mr. CHABOT. Thank you very much, Mr. Meagher.

Mr. Windle.

STATEMENT OF WESLEY S. WINDLE, PROGRAM OFFICER, PASSENGER OPERATIONS DIVISION, U.S. CUSTOMS SERVICE

Mr. WINDLE. Good morning, Mr. Chairman, and members of the committee. It is my pleasure to be here before you today. Thank you for this opportunity to respond to your concerns and questions regarding the importation of prescription drugs from Mexico.

The U.S. Customs Service mission is to prevent and deter smuggling of goods and narcotics; protect the American public against the entry of contraband and prohibited goods; regulate people, carriers, and goods that cross the U.S. border; and assess and collect duties, taxes, and fees on imports. To accomplish this mission we enforce laws and regulations of many different Federal agencies. In this particular situation, the U.S. Customs Service enforces laws and regulations for the Food and Drug Administration, (FDA), and the Drug Enforcement Administration, (DEA), governing the importation of prescription medication.

For DEA, the Customs Service enforces the laws and regulations governing the importation and exportation of prescription drugs that contain narcotics and controlled substances into and out of the United States.

For FDA, the Customs Service enforces those laws pertaining to the importation of prescription medication, including those pertaining to mislabeled, adulterated, and prohibited drugs which do not meet FDA approval, from being imported into the United States.

The effort and capabilities of the U.S. Customs Service can be seen in the seizures and/or refusals of admission of various types

of non-narcotic pharmaceuticals governed by FDA and DEA laws and regulations. Reasons for these seizures range from lack of FDA approval of a drug, to mislabeling or labeling of a product, to false and unsubstantiated medical claims. These discoveries and seizures encompass various types of medications, from exotic remedies to Rohypnol—the so-called date-rape drug.

Concerns have been raised regarding the possibly contradictory interpretations regarding the importation of prescription drugs for personal use without a valid United States prescription. Concerns have also been raised regarding allegedly inconsistent and contradictory directives from Washington, D.C., which make it difficult for officers in the field to consistently enforce the law and combat this problem.

On December 12, 1996, in an effort to assist our inspectors, the U.S. Customs Service issued, as a memorandum a prescription medicine process reminder. This reminder directly addresses the importation of prescription drugs for personal use, including prescription requirements and personal import amounts. Similar information is also available to the general public on the Customs web site at HTTP://WWW.CUSTOMS.USTREAS.GOV.

Subject to FDA approval, if an individual has a prescription, foreign or domestic, for medication for use in the United States and he presents himself and declares the medication for entry, and if it is in a personal use quantity, he is allowed to bring the controlled medication into the United States.

As stated in the reminder, Customs advice to inspectors in the field is that the totality of circumstances including, but not limited to, resident or non-resident status, drug type, and length of stay must guide the inspector in determining a legitimate personal use amount. When drug type, amount, or various drug combinations arouse suspicions, our inspectors contact the nearest FDA office for advice and final determination.

In the real world, there is some latitude in our inspectors' determinations of a legitimate personal use amount for various types of prescription medication. Over several years it has become accepted for some types of medications to be a 30-day supply, where it was considered a reasonable amount, and for others it became a 90-day supply. These quantities are generally supported by the FDA when our inspectors telephone their officers for advice and final determination.

Customs recognizes the enforcement difficulties regarding the personal importation of prescription medications. Solutions have been discussed internally within the Passenger Operations Division of the Office of Field Operations, as well as externally with DEA and FDA. Officers from the headquarters level of all three agencies have discussed this issue since the unified effort and ban on Rohypnol in early 1996.

In May 1996, Customs' McAllen Intelligence Collection Analytical Team conducted a survey of imported prescription medications. Partially in response to this survey, and partially in the knowledge that some of the issues were readily apparent, Customs prepared and issued the prescription drug process reminder and began developing a prescription medicine identification system.

The U.S. Customs Service is supportive of efforts to further improve policy regarding the personal importation of prescription drugs. Any practice or legal ambiguity that weakens our war on drugs and the purpose of prescription requirements by allowing dangerous drugs into our country without sufficient controls is a concern.

I would like to express my thanks to this committee for the opportunity to identify U.S. Customs issues regarding the importation of prescription medication.

This concludes my statement.

[The prepared statement of Mr. Windle follows:]

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I would like to express my thanks to the committee for the opportunity to identify U.S. Customs issues regarding the importation of prescription medication.

This concludes my statement.

Mr. CHABOT. Okay, thank you. I'd like to thank both witnesses for coming. And the committee members may have a few questions here. I also appreciate you taking the time to come before us this morning and sharing your knowledge and expertise, both of the witnesses.

I'd like to thank Mr. Meagher and the rest of the Inside Edition. I know that the members of the press generally shy away from serving as witnesses at Congressional hearings. However, because you recognized the severity of this problem, you've come forward to educate this committee this morning, and I thank you for that. I appreciate your commitment to putting a stop to this very dangerous situation that has been going at our Mexican border.

I'd also, again, like to thank Mr. Windle for the hard work and assistance that you and the other folks at Customs have given me during the crafting of this legislation. I appreciate your efforts to help protect our children from this very harmful situation relative to drugs.

Just a couple of questions. Mr. Meagher, in filming and researching this excellent report which you put together, you've experienced the shortcomings with the current law firsthand. To you, what was the most alarming part of the story and the investigation as you put it together?

Mr. MEAGHER. I think the ease with—with buying any type of drug you wanted across the border was, possibly, the most shocking. When we looked at how Customs is working at the border, both with their knowledge and without their knowledge, and I've have to say that all of the inspectors we saw were very hard-working, very conscientious, and taking their job very seriously, but they felt that their hands were tied.

Mr. CHABOT. And in discussing it with them, could you elaborate a little more about what their concerns were or their frustrations?

Mr. MEAGHER. Well, I mean, you can imagine the frustration. There's—there's inspectors there who have teenagers, and they're watching teenagers bring in an absurd array of drugs right up to the 90-day supply and—you know—it doesn't take a rocket scientist to find out where those drugs are headed. And they—they're

law enforcement officials, and they're watching this go right by them, and there is—or they sense there's nothing they do.

Mr. CHABOT. Thank you.

Mr. Windle, the—would a standard policy such as the "50 dosage maximum" that we have in this particular legislation be easy for Customs to enforce? And does this limit that Customs can enforce with a minimal delay and resources?

Mr. WINDLE. I believe that if you would put a limit amount, it would help. What that limit should be, again, that's to be determined. That's been discussed both with Customs, DEA, FDA, and ONDCP. Yes, some guidance would help on this. Specifics would help.

Mr. CHABOT. Mr. Meagher, do you remember approximately how many pills you brought in with you in this report? When you brought in your drugs, did the border patrol agent ask you any questions about your age, or medical problems, or anything of that nature?

Mr. MEAGHER. I purchased some drugs, the two producers purchased some drugs, and we had prescriptions to go along with them. I would say that there was little questioning to us because it might appear that we were—except for the array of drugs—purchasing them for legitimate reason, but again, I think they felt very—that their hands were tied.

Mr. CHABOT. And particularly with respect to the Rohypnol, it was—it would seem to be very evident on there that the doctor and the employees down there, they knew why people wanted that particular drug and they essentially didn't care. Would that be an accurate portrayal?

Mr. MEAGHER. Definitely.

Mr. CHABOT. Okay, thank you very much. Okay, I have no further questions at this time. At this time, we'll recognize Mr. Gekas for 5 minutes.

Mr. GEKAS. I thank you, Chair. I wanted to ask Mr. Windle, first. You stated that for several years, you had the 30-day limitation on certain drugs and 90-days of use on others. Is that correct?

Mr. WINDLE. Yes, that's current practice right now.

Mr. GEKAS. Yes. Could you tell us how far back that policy goes in your remembrance and your recollection? When you say several years——

Mr. WINDLE. Well, as long as I've been Customs.

Mr. GEKAS. Pardon me?

Mr. WINDLE. As long as I've been in Customs.

Mr. GEKAS. How long has that been?

Mr. WINDLE. Ten years.

Mr. GEKAS. Really. Does either of you have any information at all or recollection of learning about what effect NAFTA had on this situation at all, if any? The new trade agreements.

Mr. WINDLE. I wrote that down and I can pursue that. I'll see if I can get the answer for you.

Mr. GEKAS. Please do. Yes, that would be interesting to us and helpful, because we may have inadvertently created a giant loophole in NAFTA that aides and abets the problem that we have here. The only thing that millipedes against that is if you say that this policy was enforced for several years, at least 10 years, then

that preceded NAFTA; and it still continues meaning, by logic, that maybe NAFTA had no effect on this at all. But we'll—I would be—I think the members should know about that.

Mr. WINDLE. I will try to get a response for you on that.

Mr. GEKAS. And short of that, I want to help Mr. Graham get this message and legislation to a vote. Thank you very much. No further questions.

Mr. CHABOT. Thank you very much, Mr. Gekas.

Mr. Hutchinson.

Mr. HUTCHINSON. Thank you, Mr. Chairman. Mr. Windle and, I guess I'll address it to you as well, Mr. Meagher. It looks to me like the problem is not just the amount that is allowed to come into the United States, but the invalid prescription that is issued in Mexico. I think from the film that that was the major problem. Anyone can go in there and with no medical reason. You just have somebody signing off on it, is that correct?

Mr. MEAGHER. I would say so, yes.

Mr. HUTCHINSON. Does the border patrol in any way, try to determine whether there's a valid medical reason or prescription? How do you determine that?

Mr. WINDLE. At this particular point, there is no way that any one that is working on the border could have a list of all doctors in the United States or all doctors in any country that would be considered legitimate and valid prescription issuers.

Mr. HUTCHINSON. So, the only thing you can really check is what the dosage is that's coming through?

Mr. WINDLE. Right.

Mr. HUTCHINSON. Whether it's a 90-day supply or if this legislation—it specifically mentions a 50-dosage unit, that's easy to check?

Mr. WINDLE. Right.

Mr. HUTCHINSON. But as to whether there is a valid medical reason, you've got a real problem.

Mr. WINDLE. Right.

Mr. HUTCHINSON. Mr. Chairman, could you help me out here? I was just inquiring—does the legislation address that problem? Does it require a valid United States prescription or—?

Mr. CHABOT. You have to have a valid United States prescription and then you could bring in more than 50; as long as you have prescription, there's no effect—if you have a U.S. prescription. This is only for people who do not have a prescription for drugs.

Mr. HUTCHINSON. And so, this is going to address a very serious problem, which is the amount that's coming in. But you're still going to have a problem of a college student going down and getting 50 units really without any medical reason.

Mr. CHABOT. At this point, unless you wanted to eliminate any use—bringing any drug in and at.

Mr. HUTCHINSON. Which would be a really—I mean, if we tried to tighten it up even more by saying you had to have a valid U.S. prescription in order to bring in drugs—that would be difficult to enforce, wouldn't it?

Mr. WINDLE. Again, your concern becomes the non-resident who is coming into the U.S. for a visit.

Mr. HUTCHINSON. Well, the concern is—right now, you've got college kids that are going down there and getting prescription drugs and abusing them. And there's not any medical reason for it. And this is going to reduce the amount from a 90-day supply down to a 50-dosage unit, which you're going to have—maybe they'll have to make more trips now. I mean, am I correct in analyzing it this way?

Mr. MEAGHER. Some of the college students we spoke to drove between 36 and 24 hours straight to get to Laredo—in the way of Laredo. I would say the impact of the amount that they can take back and sell on campus—and we were told by counselors, by law enforcement officers—these are traffickers in prescription drugs. Certainly the impact—there would be a impact, I would imagine, on the common sense involved in driving that far to buy the drugs if you could only bring back so many.

Mr. HUTCHINSON. Well, that's very good news. That way, this would perhaps discourage and make it not cost effective in order to make the run if you're only going to be able to bring back 50-dosage units. Do many people, when you see the flow of drugs going through, Mr. Windle, are there very many that are not college students that are going there for maybe—I think you mentioned the exotic drugs—drugs that might be for some hopeful cure for cancer or something. Do you see very much of that?

Mr. WINDLE. I don't have specific numbers with me right now—as to what comes through and what doesn't, what we stop. But, yes, there are people who go down for exotic drugs that we find and catch and stop, because they are not FDA approved. Again, we deal with FDA's discretionary authority. If we find someone that has something which is not legal in the United States, we defer to them for guidance. Then they can determine what comes in and what doesn't come in.

Mr. HUTCHINSON. Well, I want thank the gentlemen, and I thank the Chair for your leadership on this. And this legislation looks like it will go a long way to solving a very difficult problem. Thank you.

Mr. CHABOT. I thank the gentleman for his questions. Would the gentleman yield for just one moment?

Mr. HUTCHINSON. Certainly.

Mr. CHABOT. Just by way of clarification, if a person was going down to Mexico, for example, for drugs for cancer treatment or something that might be a bit unusual, as long—you know, this only affects controlled substances and wouldn't affect, for example, heart medication or AIDS-type treatments, or cancer-type treatments which might be outside the mainstream. You know, this would deal strictly with controlled substances.

Mr. HUTCHINSON. Thank you.

Mr. CHABOT. Thank you. The gentleman will yield back the balance of his time.

Mr. Graham is recognized for 5 minutes.

Mr. GRAHAM. Thank you, Mr. Chairman. It's a very good report. One of the outrages to me, where it seems to be addressing some of the loopholes in our law, and Mr. Chabot deserves a lot of credit for taking leadership here. And I'm sure we're going vote in a minute, and it will be an overwhelming vote. But one of the outrages to me is the Mexican Government. What in the world are

they doing about this? Has either one of you talked to Mexican officials and exposed the problem that they have in Mexico affecting the United States? Has anyone talked with the Mexican Government at all?

Mr. MEAGHER. I did not. These pill pushers operate in the middle of the street. As a matter fact, as soon as you step on to the street of Nuevo Laredo, or Tijuana for that matter, you are besieged by these people. A group actually forms around you. And they're opening—they're operating in broad daylight.

Mr. GRAHAM. Mr. Windle, has the U.S. Customs Office ever approached——

Mr. WINDLE. I'm not privy to that level of discussion. I don't know what has been discussed with the Mexican Government in this regard.

Mr. GRAHAM. One thing I would suggest to this committee is that let the White House know the next time we certify the Mexican Government's effort to control drugs coming into the United States, we mention this problem. I can't imagine the Mexican Government not knowing about this given your story. And I can't believe we're not pushing the Mexican Government to do their part of the deal here, which is to take these guys, and shut them down, and put them in jail.

And I would encourage, Mr. Chabot—and I'd be glad to help you, and I'm sure everyone on this committee would—to try to get some involvement at the State Department to expose this problem from the Mexican Government's side of the house and talk about who regulates doctors in Mexico; and they're doing a lousy job of it.

So with that, I have no further questions.

Mr. CHABOT. I thank the gentleman very much for his comments. I think they're very well taken, and we look forward to working with him on those particular things. Gentlemen, you'll back the balance of his time. I think that's all the questions, unless any panel members thought of anything else they wanted to ask. If not, I want to thank the witnesses for their excellent testimony and for the Inside Edition report that you did. It was very, very good and very moving. And we want to thank you for the assistance. This is just a hearing today, so we won't actually have a vote. We will do that in a mark-up that would come subsequent to this. But we hope to move that forward very quickly. Thank you very much.

Mr. WINDLE. Thank you, sir.

Mr. CHABOT. Now we turn our attention to H.R. 2070, the Correction Officer Health and Safety Act of 1997, a bill introduced by Representative Gerald Solomon of New York. This bill provides that Federal employees and other persons in correctional institutions who come into contact with the bodily fluids of inmates can require that those inmates be tested for the presences of disease and that the test results be disclosed to the employee when there is reason to believe that the inmate may have a serious communicable disease.

All of us are aware of the deadly danger HIV presents today and the fact that contact with infected bodily fluids can transmit this disease. Approximately 1.5 percent of the Federal prison populations is infected with the HIV virus, but many people are not aware that other serious diseases are often present in inmate popu-

lations, diseases such as tuberculosis, and some strains of hepatitis, which can also prove to be deadly if not treated promptly. These diseases also can be transmitted through close contact with the infected prisoners.

I believe all of us can agree that we should take every precaution to protect our corrections officers and their families from the harm that these dread diseases can cause and from a physiological harm that can occur when corrections officers must wait to learn whether they have been exposed to one of these diseases.

The issue before us is to best accomplish this in a manner that is also balanced with the need to develop correctional policies that treat prisoners humanely. This bill may strike that important balance.

[The text of the bill, H.R. 2070 follows:]

105TH CONGRESS
1ST SESSION

H. R. 2070

To amend title 18, United States Code, to provide for the mandatory testing for serious transmissible diseases of incarcerated persons whose bodily fluids come into contact with corrections personnel and notice to those personnel of the results of the tests, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 25, 1997

Mr. SOLOMON (for himself and Mr. CONDIT) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To amend title 18, United States Code, to provide for the mandatory testing for serious transmissible diseases of incarcerated persons whose bodily fluids come into contact with corrections personnel and notice to those personnel of the results of the tests, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Correction Officers Health and Safety Act of 1997".

SEC. 2. TESTING FOR TRANSMISSIBLE DISEASE OF CERTAIN INCARCERATED PERSONS.

(a) IN GENERAL.—Chapter 301 of title 18, United States Code, is amended by adding at the end the following:

"§ 4014. Testing for transmissible disease

"(a) If the bodily fluids, of a person who is incarcerated in a Federal correctional facility, that are capable of causing a serious transmissible disease come into contact with any officer or employee of the United States or any other person not so incarcerated, the Attorney General shall, under such rules as the Attorney General makes to carry out this section, cause the incarcerated person to be tested for those diseases and promptly communicate in writing the results of the tests to the person with whom such fluids came into contact. If any such tests indicate that such a disease might have been transmitted, the Attorney General shall make appropriate referrals for counseling and health care and support services.

"(b) As used in this section, the term 'serious transmissible disease' means the human immunodeficiency virus (HIV) or any of its derivatives, hepatitis and any of its derivatives, tuberculosis, and any other serious illness which an exposed person might reasonably expect to contract from the contact.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 301 of title 18, United States Code, is amended by adding at the end the following:

"4014. Testing for transmissible disease.".

(c) Not later than one year after the date of the enactment of this section, the Attorney General, in consultation with the Corrections and Criminal Justice Coalition, shall make voluntary national guidelines for testing for serious transmissible diseases of incarcerated persons whose bodily fluids come into contact with corrections personnel or other persons and for the provision of notice to persons with whom those bodily fluids came into contact of the results of such tests.

○

I look forward to receiving the testimony from the witnesses before us today concerning it. And this third panel that we have consists of four witnesses and I'd like to introduce them at this time, and then we'll move to their testimony.

First, John Parcell has been a correctional officer for the State of Pennsylvania for the last 7 years. Officer Parcell currently works at the SCI Coaltown township since transferring from SCI, Dallas, in July 1997, after 4.5 years of service. Prior to becoming a correctional officer, he served in the United States Marine Corps and the United States Coast Guard for a combined total of 9 years, and we thank you very much for serving this country, sir. He is testifying today on behalf of the Corrections and Criminal Justice Coalition.

Next, we have Michael Graney, is the executive vice president of the New York council 82 of the American Federation of State, County, and Municipal Employees. He has worked as a New York State corrections officer for 17 years, most of them at Auburn Correctional Facility, a class A prison which houses some of the most violent inmates in the system. Prior to being elected executive vice president of council 82, Mr. Graney served as the president of his union local for 12 years. And thank you for coming, Mr. Graney, and Mr. Parcell.

Next, we have Marilyn Wolfe, who lives in upstate New York with her husband and two young daughters. She works part-time as a beautician while her husband works as a New York State corrections officer. Mrs. Wolfe will testify today about her own family's experience when her husband was exposed to the blood of an inmate. Thank you very much for coming this morning.

And, finally, we have Christopher Anders, who is the legislative counsel for the American Civil Liberties Union in its Washington national office. His responsibilities include HIV and AIDS issues. Before joining the ACLU last year, Mr. Anders was associated with a Washington, D.C., law firm where he represented clients in Federal and State courts and before Federal agencies. In that position, he also provided pro bono representation to HIV positive clients of the Whitman-Walker clinic who faced discrimination in employment or insurance. Prior to attending law school, Mr. Anders was a legislative representative for a consulting firm where he lobbied Congress on behalf of labor unions and municipalities on international trade and appropriations issues. So we thank all the witnesses, and I believe we'll begin with Mr. Parcell.

Mr. PARCELL. Thank you.

Mr. CHABOT. Thank you, and each witness—you can read your testimony or feel free to summarize it if you so choose. We'd ask the witnesses, if possible, to keep their testimony to about 5 minutes. And, if the clock is working, we'll—the green light means "start" and the red light means "stop." [Laughter.]

Mr. CHABOT. So, I thought we'd give you a little grace period of about 3 seconds after the red light comes on. Just kidding, a little bit longer than that. And thank you very much for coming.

STATEMENT OF JOHN PARCELL, CORRECTIONS AND CRIMINAL JUSTICE COALITION

Mr. PARCELL. Good morning. Thank you for letting me testify today, Mr. Chairman, and members. I submitted a written statement, as you folks, as you gentlemen have in front of you. I'd like to make some other additional comments.

My name—like as mentioned, my name is John Parcell, and I'm a 7 year correctional officer from Pennsylvania, and I'm accompanied today by my wife, Jeanne, and my three children—if they're in the room today—Kristy, John, and Kyla.

I'm here to testify on H.R. 2070, for Corrections Officers Health and Safety Act. I'm doing this on behalf of everybody—all correctional officers across the United States, Federal, State, and local. And I'm here to testify, along with Ms. Wolfe, for families, my family and everybody else's.

As you have in the testimony in front of you, I'd like to summarize real quick what happened to me and why I'm here. In 1995, I was spit in the face by an inmate and, subsequently, went down and had a test for HIV—or a blood test. It came out HIV positive, and waiting for the extra 14 days for a re-test put quite a strain on my family. And it came back a false positive. And due to the situation in Pennsylvania right now, and the rights the inmates have, somewhat put a strain on our family.

The disclosure—I went for disclosure and possibly getting some information if he was—any kind of disease. And, of course, by law they could not give me that—any disclosure on any information. And this could have saved me a lot of hassle and well-being—you say, mental well-being—knowing if it was disclosed—I wouldn't have had to go down there to the hospital and get the test.

If anybody thinks it's an isolated incident, it's not. It happens all over, in every local, county, State, Federal prison. And, right now, I would like to have a tape played, "Behind the Walls," produced by California Corrections and Police Officers Association.

Mr. CHABOT. Go right ahead, and we'll hear the—view the tape now.

[Tape presentation.]

Mr. CHABOT. Well that's tough stuff.

Mr. PARCELL. And, as you can see, this is not an isolated incident. The—it's on the rise, at least in our prisons in Pennsylvania, this is on the rise. I'm sure from the tape, you can see it's on the rise from everywhere else, too.

I understand that the bill being presented, the CCJC and Mr. Solomon have been working on. Right now, it only sets down for Federal's corrections. I would like to see the guidelines be set for State mandates for State CO's and local CO's in the States. Be-

cause we're all in the same ball game. I think the disclosure portion of it to have an inmate tested if there is a fluid to body contact of any kind, because it is necessary for the family's sake and the officer's sake.

On a personal note, I hope when this bill was passed that the guidelines are set forth to the States, like I mentioned before. And somehow can be adhered to and have the States adhere to them via the Federal Government. Because its pretty hair raising when you find out you got a positive test, then it comes out to a false positive. It just changes your whole life.

[The prepared statement of Mr. Parcell follows:]

PREPARED STATEMENT OF JOHN PARCELL, CORRECTIONS AND CRIMINAL JUSTICE COALITION

I want to thank Chairman McCollum and the Members of the Crime Subcommittee for allowing me to testify in favor of H.R. 2070, the Correction Officers' Health and Safety Act, today.

H.R. 2070 is one of the most critical pieces of health and safety legislation this Congress will consider from the point of view of the nation's 300,000 correctional officers.

H.R. 2070 directly affects correctional officers in the federal prison system. But, the precedent it sets and the guidelines it promises to create will save a countless number of my colleagues at every level of correction work.

This measure is aimed specifically at requiring medical testing of federal prisoners who threaten the lives of correctional officers, either inadvertently or directly, though contamination with some bodily fluid that is capable of transmitting a contagious disease.

The principles set forth in H.R. 2070 touch a very raw nerve with me and with my fellow correctional officers. In prison today, correctional officers face an increasingly difficult inmate population who have devised very creative and very deadly ways to perpetuate their lives of wanton criminal violence even though they are behind some of the most secure prison walls in the history of the nation. That violence takes many forms. But the form that prompted the formulation of H.R. 2070 and that brings me before you is particularly insidious.

I say that because not only are the lives of correctional officers threatened, but those of their families are threatened as well. I am talking of the growing threat posed by inmates carrying infectious and potentially lethal diseases and those inmates who claim to be infected.

I am talking about the potential of me and any of my fellow correctional officers contracting one or more deadly or debilitating diseases in the course of our duties and possibly infecting innocent members of our families.

I am talking about officers rushing, as part of their sworn duty, to the aid of inmates cut and bleeding from assaults by their fellow inmates only to be inadvertently splashed by diseased fluids and contracting HIV, Hepatitis, tuberculosis, or any of a number of contagious and life-threatening viruses.

I am also talking about hideous mixtures of potentially disease-laced blood, urine, feces, spit and semen intentionally thrown on correctional officers in deliberate attempts to infect them. Inmates call this horrendous practice "gassing" or "being served." Such behavior is not isolated. In fact, it's becoming more and more common place. It's a way to gain stature within a prison population. It's a badge of honor to "serve" a correctional officer such a deadly mix.

And deadly it is.

Last December, the nation's research community was shocked at the death of a young, 22-year-old research assistant named Elizabeth R. Griffin who worked with macaque monkeys at Emory University's Yerkes Regional Primate Research Center. She contracted Hepatitis B and died 42 days after one of the research monkeys splashed her in the eye with a contaminated bodily fluid. The transmission of that disease through the mucous membrane of the young researcher's eye radically revised the safety precautions of the nation's research facilities. Her death occurred barely three months ago.

For nearly a decade, the nation's prisons have been cauldrons of contagious and equally deadly or debilitating diseases. HIV, AIDS, Hepatitis A, B, and C, tuberculosis, and sexually transmitted diseases such as syphilis, chlamydia and gonorrhea.

The fetid concoctions thrown on correctional officers not only seep into their eyes but more often than not splash into nostrils and, as repulsive as it sounds, into the officers mouths.

After such hideous attacks officers have no recourse but to wait. They wait to see if they are among the walking, soon to be dead. I am not exaggerating. Correctional officers are dying and suffering untold pain not just because of the successful transmission of any number of viral infections via such unspeakable acts but by the accompanying threat.

I am sure you can all picture how degrading this attack can be to a correctional officer, but think for a minute how you would feel when the inmate whispers to you "Now you've got it too." How intimidated would you feel? Would you want to kiss your spouse or child when you went home after work?

H.R. 2070 will save correctional officers, their spouses and their children in a very practical way. It will help them to identify and treat life-threatening contagious diseases before their livers need to be transplanted because of the ravages of hepatitis. It will also save them from the incomprehensible mental anguish I suffered not knowing whether I was infected with some fatal and incurable disease after being assaulted by an inmate.

I cannot describe to you the way your entire world seems to collapse around you when you find yourself covered in inmate spit or worse and you realize you have no way of know whether the inmate in question is capable of transmitting a deadly incurable disease.

Because the doctors and nurses at the prison could not release information on the inmate who spit in my eye, I had to have myself tested. I had to wait for 3 days for the results and then I cannot adequately convey the terror of being notified that my blood test had turned out positive for HIV. I will let your imagination deal with the thoughts that flood through your mind as you contemplate the rest of your life and your wife and children living without you.

In my case that positive test result proved to be "false positive" so I only lived with the terror for 10 days. I was lucky, but I could introduce you to colleagues who were not so lucky.

H.R. 2070 can reverse these too often repeated scenarios.

And it can do it with dignity. H.R. 2070 is designed to preserve not only the lives of those involved but also the privacy of the inmates themselves.

One of the problems with HIV/AIDS infected inmates is that they comprise a small proportion of the overall inmate population. They are but 1.4 percent of federal prison inmates and 2.3 percent of state prison inmates. Unfortunately, these diseased inmates are not segregated from the general prison population. Consequently, correctional officers have no way of knowing which inmate has disease threat potential.

H.R. 2070 respects the overall prison population by targeting only that inmate or those inmates suspected of or identified as being responsible for transmission of bodily fluids to correctional officers either inadvertently or intentionally for medical testing. That testing is confidential and the results are given only to the officer involved in the incident.

H.R. 2070 also respects the right of the states to determine how they will safeguard their own correctional officers.

H.R. 2070 directs the Attorney General to work with correctional officers to develop guidelines for such disease testing to be made available to the states. I want to emphasize that these guidelines are not only voluntary but they are very much in keeping with the original mandate given Congress in dealing with the states. That is they provide in the spirit of cooperation and sharing the best thinking, technology and information in the nation and avail that data to the states so they might better provide for the health and welfare of their residents.

AIDS is currently the leading cause of death among inmates in many correctional facilities. The rising trend of AIDS deaths among inmates strongly suggests it will remain the leader in inmate deaths by the millennium.

If this Congress enacts H.R. 2070 into law, you and your fellow members of Congress will have taken the single most important step to keep AIDS and other transmissible diseases from becoming the leading cause of death among the nation's correctional officers.

On behalf of myself, my family and my colleagues in the federal and state prison systems and in correctional facilities in municipalities and counties across the nation I ask that you make that goal among your top legislative priorities.

Mr. CHABOT. Thank you very much, Mr. Parcell, very persuasive testimony; appreciated it, especially in conjunction with the tape. Thank you.

Mr. Graney.

STATEMENT OF MICHAEL GRANEY, EXECUTIVE VICE PRESIDENT, NEW YORK COUNCIL 82, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

Mr. GRANEY. Mr. Chairman, and other members, thank you for the opportunity here today. My name is Mike Graney. I am currently executive vice president of Council 82 of the American Federal of State, County and Municipal Employees, which is called AFSCME. I appreciate the opportunity to testify on H.R. 2070, the Corrections Officers Health and Safety Act of 1997. AFSCME has more than 100,000 members who work in the corrections profession across the Nation.

AFSCME Council 82 represents 26,000 law enforcement personnel, State corrections officers and municipal police, in the State of New York. Our members have dedicated themselves to making the public feel safer in their homes and in their communities. In turn, we must do what we can to ensure the safety of corrections officers and police. This important legislation introduced by our good friend, Representative Gerald Solomon, is a step in the right direction. It amends the Federal criminal code to provide for mandatory testing for serious transmissible diseases of incarcerated persons whose bodily fluids come into contact with corrections personnel, crime victims, paramedics, and other prison employees in Federal correctional facilities. The bill also provides for referrals for counseling, health care, and support services if testing indicates that a disease was transmitted.

The legislation responds to a major problem confronting law enforcement officers who must come into close personal contact with inmates carrying serious transmissible diseases. Corrections officers frequently have been physically assaulted by inmates and even had blood and other bodily fluids thrown at them, all of which jeopardize their health and safety. Officers who have been subjected to such treatment have had their health seriously threatened and have had to face the very real risk they would carry the disease back to their families. This, of course, causes them to suffer great emotional and physical stress, and in the very worst case, their death.

Marilyn Wolfe is here to tell you the real life story of her husband who was involved in a significant blood exposure incident while on the job as a New York State correction officer. It is a devastating story and points out the need for this bill—and the real need for this bill to cover State and local law enforcement officers, as well as Federal corrections officers.

Even though the bill calls for the Attorney General, no later than 1 year after the date of enactment to make voluntary national guidelines for testing of inmates, the key word here is "voluntary." It would be up to those States and cities to enforce it or choose not to.

This is unsatisfactory and not sufficient to protect the interests of the thousands of State and municipal law enforcement officers all over the country who are subjected to this danger everyday they go to work. We strongly urge that H.R. 2070 be amended to cover the State and local Government corrections officers.

A serious—a very serious and deadly blood-borne disease for which there is no known cure or vaccine and causes long-term liver damage is hepatitis C. A report by the California Center for Health Improvement estimates that as many as 40 percent of incarcerated males and 50 percent of incarcerated females are infected with hepatitis C.

Another suggestion for improvement in this bill would be to have a wider and broader community of groups included as consultants. We urge the subcommittee to include AFSCME Corrections United as a consultant since we represent over a 100,000 public corrections officers and other personnel around the country.

AFSCME strongly endorses H.R. 2070 with the changes outlines above. While in the past, an action such as spitting on a person was seen as an insult and "gross" behavior, we now know the potential ramification go far beyond simple indignity. We urge you to keep this in mind as you work to bring public policy into line with our scientific knowledge and to protect corrections employees from exposure to diseases in the work place. We believe this is an important first step in achieving this goal.

Thank you.

[The prepared statement of Mr. Graney follows:]

PREPARED STATEMENT OF MICHAEL GRANEY, EXECUTIVE VICE PRESIDENT, NEW YORK COUNCIL 82, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

My name is Michael Graney. I am Executive Vice President of New York Council 82 of the American Federation of State, County and Municipal Employees (AFSCME). I appreciate the opportunity to testify on H.R. 2070, the Corrections Officers Health and Safety Act of 1997, before the House Judiciary Subcommittee on Crime. AFSCME has more than 100,000 members who work in the corrections profession across the nation.

AFSCME Council 82 represents 26,000 law enforcement personnel—state corrections officers and municipal police—in the state of New York. Our members have dedicated themselves to making the public feel safer in their homes and in their communities. In turn we must do what we can to ensure the safety of corrections officers and police. This important legislation, introduced by Representative Gerald Solomon, is a step in the right direction. It amends the federal criminal code to provide for mandatory testing for serious transmissible diseases of incarcerated persons whose bodily fluids come into contact with corrections personnel, crime victims, paramedics, and other prison employees in federal correctional facilities. The bill also provides for referrals for counseling, health care and support services if testing indicates that a disease may have been transmitted.

The legislation responds to a major problem confronting law enforcement officers who must come into close personal contact with inmates carrying serious transmissible diseases. Corrections officers frequently have been physically assaulted by inmates and even had blood and other bodily fluids thrown at them, all of which seriously jeopardize their health and safety. Officers who have been subjected to such treatment have had their health seriously threatened and have had to face the very real risk that they would carry a disease back to their families. This, of course, causes them to suffer great emotional and physical stress and, in the worst case scenario, death.

Marilyn Wolfe is here to tell the real life story of her husband who was involved in a significant blood exposure incident while on the job as a state corrections officer. It is a devastating story and points out the need for this bill—and the real need for this bill to cover state and local law enforcement officers as well as federal corrections officers. Even though the bill calls for the Attorney General, no later than one year after the date of enactment, to make voluntary national guidelines for testing of inmates, the key word here is "voluntary." It would be up to the states and cities to enforce it or choose not to. This is unsatisfactory and not sufficient to protect the interests of the thousands of state and municipal law enforcement officers all over the country who are subjected to this danger on a daily basis. Accordingly, we strongly urge that H.R. 2070 be amended to specifically cover state and local government corrections officers.

Over the past 20 years, there has been a significant advancement in medical research towards identifying previously unknown pathogens, particularly viruses, as well as the discovery of new pathogens. Still we do not have a complete and definitive picture of infectious diseases that target the human body. We do know that many human pathogens are carried in the cells of our body tissues and body fluids. In order to prevent the transmission of these diseases, we need to prevent the transfer of pathogens from an infected individual to another person. Only some states have taken steps to deter such behavior by imposing penalties upon those who practice it. In my home state of New York, the penal law was amended by adding a new section: 240.32 Aggravated Harassment of an Employee by an Inmate. Any inmate or respondent youth who causes an employee to come into contact with blood, seminal fluid, urine or feces commits a felony. This law affects not only correctional employees, but also any employee of the Division of Parole and the Office of Mental Health.

A very serious, and deadly, bloodbourne disease for which there is no known cure or vaccine and causes long-term liver damage is hepatitis C. A report by the California Center for Health Improvement estimates that as many as 40 percent of incarcerated males and 50 percent of incarcerated females are infected with hepatitis C.

Another suggestion for improvement in this bill would be to have a wider and broader community of groups included as consultants. We urge the Subcommittee to include AFSCME Corrections United as a consultant since we represent over 100,000 public corrections officers and other personnel around the country.

AFSCME strongly endorses H.R. 2070 with the changes outlined above. While, in the past, an action such as spitting on a person was seen as a insult and "gross" behavior, we now know the potential ramifications go far beyond simple indignity. We urge you to keep this in mind as you work to bring public policy into line with our scientific knowledge and to protect corrections employees from exposure to diseases in the workplace. We believe this is an important first step in achieving this goal.

BIOGRAPHY

Michael G. Graney, 39, Executive Vice President of AFSCME Council 82, has worked as a New York State Correction Officer for 17 years, most of them at Auburn Correctional Facility, a Class A prison which houses some of the most violent inmates in the system.

He is a native of Auburn, New York, site of one of the state's oldest prisons.

Mr. Graney served as the President of his local union for 12 years, before being elected executive vice president of Council 82.

Mr. CHABOT. Thank you, Mr. Graney.

Ms. Wolfe.

STATEMENT OF MARILYN WOLFE

Ms. WOLFE. Thank you, Mr. Chairman. My name is Marilyn Wolfe, and I appreciate the opportunity to testify on H.R. 2070, the Corrections Officers Health and Safety Act of 1997. I have been married to my husband, Walter, for almost 14 years. He's been a New York State correction officer since July 1985. We have two beautiful daughters, Erica Lynn who is 9, and Melissa Rose who is 6. I work part-time as a beautician, but I spend most of my time taking care of my family and home. The reason I am telling you about my family is, they are why I am here today.

In September 1996, our whole lives changed. When my husband came home from work that day, our nightmare began. In the course of carrying out his duties at work he was involved in a significant blood exposure incident resulting in a direct blood-to-blood contact with an inmate. The immediate change in our lives was dramatic. No only was I scared to death for my husband, myself, and my children, but then I found out the unbelievably unfair laws dealing with this issue. A day or so after the incident, the inmate was asked if he would consent to an HIV test. He refused; 3 days later he was again, and once again he refused. He did not have to

tell us his HIV status. It's against his rights. The convicted felon had more rights than my family. We have worked hard for a decent life. My husband has a good job, we own our own home, pay our taxes, and are raising our family. But with all that, it appears convicted criminals have more rights than us. They have the laws on their side. As crazy as it sounds, according to the law, if my husband was having sex with the inmate, the doctor could tell him if he was HIV positive, but because we're good, decent people, we cannot be told. This is insane to me, and I will never understand it.

The inmate whose blood contacted my husband's should have been mandated to take an HIV test. If we had known for sure if the inmate's status was positive, we would have dealt with the results. But not being able to know is so hard on a family. Our whole lives were changed. We became afraid to touch one another intimately because of the possibility of him becoming positive. He became over cautious around the kids, and they worried why their father would not play with them so much anymore. He said it was too late for him. If he was to become positive, there was nothing that could be done, but he would never take that chance with his wife and daughters.

When my husband started this job over 12 years ago, he understood the risks. He agreed to them, and lives with them every day since. I am very proud of him. He has an extremely hard job and does it well. However, I did not take that job, or agree to the risks that go along with it. But then my life was suddenly on the line like his. What happens if, God forbid, my husbands turns HIV positive? What then? If we had known for sure the inmate;s status was positive, he would have been put on medications right away. But because we could not find out, my husband was not given anything which could have further jeopardized our lives. Instead, we were put through the most humiliating counseling and testing ever.

When is someone is tested for HIV and gets a positive result, nothing can be done to them. You cannot be arrested for it. You can't lose your driver's license for it. It cannot be used against you for anything. If you're an inmate, the only thing that happens is you get all of the treatment and medications that you need. There is no good reason for not mandating HIV testing for inmates when a significant blood exposure has occurred with an officer.

I have tried to make sure a new law is enacted in New York State to cover this specific issue, and it is almost there. Any person who exposes another person should be made to take an HIV test immediately and then again in 6 months, with the results being made available to the exposed party. No one, especially convicted criminals, should have the right to put anyone through the torment and heartache that my family went through.

In addition to covering corrections officers, a law like this could protect nurses, doctors, police officers, and any individual who works in the criminal justice system.

I know it is too late to help my husband and family, but I cannot sit by and let someone else go through this nightmare—I had to do something about it. I hope coming here today and telling you my family's story will help you understand how important a law like this is to so many people and families.

Thank you.

[The prepared statement of Ms. Wolfe follows:]

PREPARED STATEMENT OF MARILYN WOLFE

My name is Marilyn Wolfe. I appreciate the opportunity to testify on H.R. 2070, the "Correction Officers Health and Safety Act of 1997." I have been married to my husband Walter for almost fourteen years. He has been a New York State Correction Officer since July of 1985. We have two beautiful daughters, Erica Lynn who is nine and Melissa Rose who is six. I work part time as a beautician, but I spend most of my time taking care of my family and home. The reason I am telling you about my family is, they are why I am here today.

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When someone is tested for HIV, and gets a positive result, nothing can be done to them. You cannot be arrested for it. You cannot lose your driver's license for it. It cannot be used against you for anything. If you are an inmate, the only thing that will happen is you get all of the medications and treatments you need. There really is no good reason for not mandating HIV testing for inmates when a significant blood exposure has occurred with an officer.

I have tried to make sure a new law is enacted in New York State to cover this specific issue and it is almost there. Any person who exposes another person should be made to take an HIV test immediately, and then again in six months, with the results being made available to the exposed party. No one, especially convicted criminals, should have the right to put anyone through the torment and heartache that my family went through.

On addition to covering corrections officers, a law like this could help protect nurses, doctors, police officers, and any individual who works in the criminal justice system.

I know it is too late to help my husband and family, but I cannot sit by and let someone else go through this nightmare—I have to do something about it. I hope coming here today to tell you my family's story will help you to understand how important a law like this will be to so many people.

Mr. CHABOT. Thank you very much.

Mr. Anders.

STATEMENT OF CHRISTOPHER E. ANDERS, LEGISLATIVE COUNSEL, AMERICAN CIVIL LIBERTIES UNION

Mr. ANDERS. Thank you, Mr. Chairman. The American Civil Liberties Union appreciates the opportunity to present our analysis of the likely consequences of interfering in the Federal prison system by imposing the requirements contained in H.R. 2070. I ask that my full written testimony be inserted in the record.

Mr. CHABOT. Without objection.

Mr. ANDERS. I would like to clarify two points right from the start. H.R. 2070 applies only to the Federal prison system. It does not apply to State and local prison systems. In terms of what's going on in the Federal prison system right now, the Bureau of Prisons applies its own guidelines which include CDC guidelines on how to handle situations wherever there is a possibility of transmission of HIV or any other blood-borne disease. Those guidelines are also available for State and local Governments if they choose to apply them. In fact, the Bureaus of Prisons guidelines are available on their web site at bop.gov.

The other point that I'd like to raise right from the very start is that in a December 1995 report, the Justice Department made clear that there's never been a job-related, inmate-to-corrections officer transmission of HIV. There also have been no cases of HIV being transmitted by saliva.

H.R. 2070 needlessly compromises the privacy of both inmates and Federal corrections officers and, thereby, jeopardizes the physical safety of both inmates and corrections officers by requiring an HIV test of an incarcerated person whenever a corrections officer comes into contact with the bodily fluids of that incarcerated person—even if that contact carries absolutely no risk of HIV transmission.

The Government must then communicate the test results, in writing, to the person with whom such fluids came into contact. However, the legislation does not provide any process for ensuring either the anonymity or confidentiality of the person being tested, the test results themselves, or the person receiving the test results. In fact, the Government will not have any discretion in deciding whether to administer the test or communicate the results—even if the purported beneficiary of the test result, i.e., the corrections officer, does not want to receive the test result. Thus, H.R. 2070 requires testing regardless of the risk of transmission, regardless of whether the corrections officer wants to know the inmate's test result, regardless of the corrections officers pre-contact HIV status, and regardless of whether the prison can adequately protect the confidentiality of the inmate's test result.

The danger to a prisoner resulting from disclosure of his or her HIV-positive status is significant. Other prisoners may discriminate against that prisoner, including subjecting that prisoner to violence. An HIV-positive prisoner may be left with little or no medical care.

Ironically, a corrections officer's receipt of an inmate's test results may trigger a chain of events that could cause problems for the corrections officer that may be at least as severe as the problems caused to the inmate. When a corrections officer's contact with an inmate's bodily fluids prompts an HIV test, other members

of the prison community may begin to treat both the inmate and the corrections officer as if they have, or will have, the same HIV status.

In addition, the mandatory testing of prisoners regardless of the risk caused by the contact also deprives corrections officers of their ability to control when and where they will be tested. The standard evaluation and treatment protocol recommended by the 1998 CDC guidelines is to administer a baseline HIV test to the potentially exposed person.

Thus, the corrections officer may be subjected to an HIV test that could reveal his or her HIV status—even when an inmate's action had no effect on that status, and even when there may have been no possibility of transmission. That test result, if disclosed to others, could further expose the corrections officer to discrimination.

The Federal Bureau of Prisons regulations obviate the need for this legislation. Moreover, the consensus on the effectiveness of prophylactic treatment for HIV is that treatment should begin within hours of exposure. An HIV-positive test result from an inmate may arrive too late to be of any use to a corrections officer in deciding whether to begin prophylactic treatment.

Instead of passing H.R. 2070, the ACLU urges the subcommittee to work with the Bureau of Prisons to ensure that all persons in the Federal prison community have access to adequate health care to reduce the transmission of HIV and other diseases and to treat those persons who already are infected. Thank you.

[The prepared statement of Mr. Anders follows:]

PREPARED STATEMENT OF CHRISTOPHER E. ANDERS, LEGISLATIVE COUNSEL, AMERICAN CIVIL LIBERTIES UNION

I. INTRODUCTION

Mr. Chairman and members of the Subcommittee on Crime, the American Civil Liberties Union appreciates this opportunity to present our analysis of the likely consequences of interfering in the federal prison system by imposing the requirements contained in H.R. 2070. The ACLU urges the members of the Subcommittee to oppose H.R. 2070 because it will likely further endanger the health and safety of both incarcerated persons *and* corrections officers, intrude on important medical privacy rights of incarcerated persons and corrections officers, expose corrections officers to possible employment discrimination, and misallocate scarce public health funds within the federal prison system.

Since nearly the start of the HIV/AIDS crisis, the American Civil Liberties Union has worked to protect the civil rights and civil liberties of persons with HIV and AIDS. Specifically, the ACLU has fought discrimination against persons with HIV and AIDS in workplaces and communities, protected persons with HIV and AIDS against invasions of their most basic privacy, and worked to ensure equal access to adequate health care. Based on the ACLU's analysis of H.R. 2070, the ACLU believes that, within the federal prison system, as in most other contexts, protecting persons from discrimination and invasions of privacy is consistent with protecting public health.[1]

[1] Although H.R. 2070 requires testing for HIV, hepatitis, tuberculosis, and certain other transmissible diseases, this testimony focuses on HIV because fear of HIV appears to be the impetus for the legislation. In addition, the Centers for Disease Control and Prevention's 1998 Guidelines for Treatment of Sexually Transmitted Diseases state that the protocol for treating an adult who was potentially exposed to hepatitis B is to administer a hepatitis vaccine, and the protocol for treating an adult who was potentially exposed to sexually transmitted diseases other than HIV is to administer an antimicrobial regimen. Those Guidelines do not recommend any deviation from those two protocols based on any other person's health status.

II. TESTING AND DISCLOSURE MAY THREATEN THE SAFETY OF PRISONERS AND CORRECTIONS OFFICERS

H.R. 2070 may threaten the physical safety of both incarcerated persons *and* corrections officers. The bill would require that federal prisons administer HIV and other medical tests to any incarcerated person whose bodily fluids came into contact with any non-incarcerated person, and then provide those test results to that non-incarcerated person.

H.R. 2070 needlessly compromises the privacy of both inmates and corrections officers, and thereby jeopardizes the physical safety of both inmates and corrections officers, by requiring an HIV test of an incarcerated person whenever a corrections officer or other non-incarcerated person comes into contact with the bodily fluids of that incarcerated person. The government must then communicate the test results, in writing, to the person with whom such fluids came into contact. However, the legislation does not provide any process for ensuring either the anonymity or confidentiality of the person being tested, the test results themselves, or the person receiving the test results. In fact, the government will not have any discretion in deciding whether to administer the test or communicate the results—even if the purported beneficiary of the test result, i.e., the corrections officer, does not want to receive the test result. Thus, H.R. 2070 requires testing regardless of the risk of transmission, regardless of whether the corrections officer wants to know the inmate's test results, regardless of the corrections officer's pre-contact HIV status, and regardless of whether the prison can adequately protect the confidentiality of the inmate's test result. Moreover, in the closed system of a prison, any loss of confidentiality may well result in widespread disclosure of the person's HIV status.

The danger to a prisoner resulting from disclosure of his or her HIV-positive status is significant. Other prisoners may discriminate against that prisoner, including subjecting that prisoner to violence. Corrections officers may retaliate. And the HIV-positive prisoner may be left with little or no medical care.

The danger that may be less obvious is the impact on the corrections officers. Ironically, a corrections officer's receipt of an inmate's test results may trigger a chain of events that could cause problems for that corrections officer that may be at least as severe—and just as unnecessary—as the problems caused to the inmate. When a corrections officer's contact with an inmate's bodily fluids prompts an HIV test, other members of the prison community may begin to treat both the inmate and the corrections officer as if they have, or will have, the same HIV status. If the inmate's test result is positive, the corrections officer may have difficulty working in a closed prison system where inmates may treat the officer differently based on their assumption that the corrections officer is also HIV positive.

TESTING AND DISCLOSURE MAY EXPOSE CORRECTIONS OFFICERS TO EMPLOYMENT DISCRIMINATION

In addition to jeopardizing the personal safety of corrections officers, the lack of any protection of the anonymity or confidentiality of test results may expose corrections officers to employment discrimination based on perceived HIV status. Many members of the prison community may mistakenly assume that an inmate's HIV-positive test result means that any person coming into contact with that inmate's bodily fluids is also HIV-positive, even if the contact had absolutely no risk of transmission. However, the irrational fear of HIV may prompt others to perceive the corrections officer as being HIV-positive and to discriminate against that officer. That officer may suffer job discrimination until and unless that officer proves to his or her colleagues that he or she is HIV-negative.

The mandatory testing of prisoners regardless of the risk caused by the contact also deprives corrections officers of their ability to control when and where they will be tested. The standard evaluation and treatment protocol recommended by the 1998 CDC Guidelines for a person who may have been exposed to HIV is to administer a baseline HIV test. Thus, the corrections officer may be subjected to an HIV test that could reveal his or her HIV status—even when an inmate's actions had no effect on that status. That test result, if disclosed to others, could further expose the corrections officer to discrimination.

IV. THE TESTS WILL PROVIDE LITTLE OR NO USEFUL INFORMATION

The risk of HIV transmission from an inmate to a correctional officer is extremely low. In a report issued in December 1995, the Justice Department's National Institute of Justice stated that "no job-related cases of HIV infection were reported among correctional officers." Moreover, the Justice Department reported "[n]o confirmed cases of occupationally acquired HIV infection have occurred among emer-

gency medical technicians or paramedics, the category with exposure risks closest to those of correctional officers."

By failing to specify which "bodily fluids" and what type of "contact" trigger a mandatory test, H.R. 2070 would require tests even where the risk of HIV transmission is effectively absent. The Justice Department has reported that "HIV has never demonstrably been transmitted through saliva." Also, in a Texas state study of 2,000 incidents of inmates exposing corrections officers to inmates' bodily fluids, primarily by throwing human waste, none of the officers became HIV-positive.

Moreover, the consensus on the effectiveness of prophylactic treatment for HIV is that treatment should begin within hours of exposure. An HIV-positive test result from an inmate may arrive too late to be of any use to a corrections officer in deciding whether to begin prophylactic treatment.

Finally, the federal Bureau of Prisons (BOP) requires that each federal prison must apply CDC and BOP guidelines in practicing universal protection practices. Those BOP guidelines have effectively prevented any transmission of HIV from prisoners to corrections officers in the federal prison system. In short, there is no need for H.R. 2070.

V. H.R. 2070 WOULD VIOLATE THE CONSTITUTIONAL RIGHTS OF INCARCERATED PERSONS

The broad scope of H.R. 2070 clearly violates the constitutional rights of incarcerated persons. Even if the provision applies only to convicted persons—which is unclear from the reference to "a person who is incarcerated in a federal correctional facility"—it still goes well beyond meeting any legitimate penological interest of the federal government.

While prisoners do not have the same right to privacy as those who are not incarcerated, they are not stripped of all constitutional rights at the prison gates. *Harris* v. *Thigpen*, 941 F.2d 1495, 1512–13 (11th Cir. 1991). Prisoners retain some rights to privacy, including a right to keep information about their HIV status confidential. *Id.* at 1513.

The constitutional right to privacy includes both "the individual interest in avoiding disclosure of personal matters" and "the interest in independence in making certain kinds of important decisions." *Whalen* v. *Roe*, 429 U.S. 589, 599 (1977). Specifically, the right to privacy includes protection against unwarranted disclosure of one's medical records or conditions. *Nolley* v. *County of Erie*, 776 F.Supp. 715, 729 (W.D.N.Y. 1991). Information that a person is HIV-positive is among the most sensitive of all medical information, given the particular stigma imposed on persons with HIV and AIDS. *Cain* v. *Hyatt*, 734 F.Supp. 671, 680 (E.D. Pa. 1990).

Courts have held that prisoners' privacy concerns must give way to concerns about prison administration, and courts often defer to prison administrators on many prison management decisions. *Turner* v. *Safley*, 482 U.S. 78, 87 (1987). However, that deference is not unfettered. Prison regulations may infringe on the constitutional rights of prisoners if the regulations are not reasonably related to a legitimate penological interest. *Id.* at 89. H.R. 2070 may very well fail that test because there is no rational connection between the bill's mandatory testing requirements and any governmental interest in protecting the health and safety of corrections officers. Tests that provide little or no useful diagnostic information, and are administered after an incident that poses no significant risk of disease transmission, deprive the legislation's provisions of any reasonable relationship to the goal of enhanced health and safety. For that reason, H.R. 2070 may fail even the relatively lenient test set by the Court in *Turner*.

VI. ANY VOLUNTARY PUBLIC HEALTH GUIDELINES SHOULD BE SET BY PUBLIC HEALTH OFFICIALS, NOT BY LAW ENFORCEMENT

Paragraph (c) of H.R. 2070 requires that the "Attorney General, in consultation with the Corrections and Criminal Justice Coalition," shall develop "voluntary" national testing guidelines for transmissible diseases in state and local prisons. That requirement is nothing more than law enforcement advising law enforcement on important medical issues. Not only does the Attorney General lack the scientific public health expertise to develop such guidelines, but she will have to consult a law enforcement and corrections coalition that also lacks any such medical expertise.

Although the guidelines may be "voluntary," state and local prison officials will likely follow any guidelines promulgated by the Justice Department in order to avoid being subject to additional tort liability for failure to follow federal guidelines, even if those guidelines have little or no scientific basis. Moreover, even if the guidelines are appropriate for some prisons, they may not be appropriate for the full range of prisons and jails in all fifty states.

VII. A FEDERAL MANDATE ON STATE AND LOCAL PRISONS MAY UNDERMINE EFFECTIVE STATE AND LOCAL POLICIES

As introduced, H.R. 2070 would apply only to the federal prison system. However, the ACLU understands that at least some supporters of H.R. 2070 are urging the Subcommittee to apply H.R. 2070's mistaken provisions to all state and local prisons and jails in all fifty states. That federal mandate could undermine effective state and local infectious disease management policies.

During the February 5, 1998 hearing on HIV transmission issues, held by the House Subcommittee on Health, several state and local public health officials urged the Congress to refrain from imposing any federal mandate on fifty state systems and thousands of local governments in the absence of any compelling public health evidence that the federal government's solution would work in all states and localities. The demographic characteristics of the disease vary from state to state and states have already implemented their own specific public health care management programs for HIV and sexually transmitted diseases.

Before imposing any public health mandate on the states, the Congress should carefully consider and address the medical concerns raised by that mandate. Frankly, this hearing provides no scientific basis for such a federal mandate. The preliminary list of witnesses includes two anecdotal witnesses, one labor union official, and one civil rights lawyer, but no public health practitioners. The Congress should not impose any federal mandate that could have significant—and potentially grave—public health consequences for both incarcerated persons and corrections officers in state and local prisons until and unless the Congress can ensure that the federal mandate will not undermine effective programs run by state or local governments. At this point, the Congress does not have a sufficient base of scientific information to provide that assurance.

VIII. CONCLUSION

The ACLU urges the members of the Subcommittee to oppose H.R. 2070 because it undermines the very health and safety objectives that the Subcommittee has worked to achieve. Instead, the ACLU urges the Subcommittee to work with the Bureau of Prisons to ensure that all persons in the federal prison community have access to adequate health care to reduce the transmission of HIV and other diseases and to treat those persons who already are infected.

Mr. CHABOT. Thank you and we thank all the witnesses for testifying. The panel members may have a few questions of the witnesses. And I'll start off here briefly.

Mr. Anders, you stated in your testimony, I believe, that there's never been a documented case of transferring of HIV from a prisoner to a guard. Is that what you said?

Mr. ANDERS. That was in a December 1995 report from the Justice Department.

Mr. CHABOT. Do you think that's any reassurance to a family that's had something like happened to Ms. Wolfe's family. Do you think they would think, "Well, there's is nothing to worry about then."?

Mr. ANDERS. It should be part of the counseling that's done by medical professionals who should be evaluating the risk and whether there is a risk of transmission in the contact. The legislation, as it's written right now, is so broad that, in terms of HIV, a lot of the contacts that would be covered by the bill have no risk of transmission. The bill covers all contacts with bodily fluids, but very few contacts with bodily fluid have any real risk of transmission of HIV.

Mr. CHABOT. Mrs. Wolfe, of the fact that Mr. Anders stated with that, would that have created a situation or would that have relieved the strain that your family went through knowing such a fact like that or—?

Ms. WOLFE. This was called a significant exposure. His hand was cut open; the inmates blood covered the arm. That's——

Mr. CHABOT. Could you pull the microphone—thank you.

Ms. WOLFE. His hand was cut open; the inmate's blood was completely covering the cut, his arm, his uniform. That's not a minor risk. That's a big risk. This immediate medication—now since my husband has gone through this—most of them when it happens, start immediately. If the inmate takes the test—or agrees to take this little test—and let you know, you can stop the medication. But you need to know; your whole life is affected. This is not a little risk. This is your whole life.

As an example, in the middle of going through all this, to add some stress to our lives, my sister-in-law had some trouble at home. We wanted to take my niece in as a foster child. We couldn't; we don't know my husband's HIV status. You need to know that to become a foster parent. But the inmate has rights, not us.

Mr. CHABOT. And following up on that statement there, Mr. Anders, I have another question. In your testimony, you raised the possibility of discrimination against the inmate if his or her HIV-positive status became known as part of why the ACLU opposes this bill. Why do you weigh the balance in favor of the inmate's needs and against the corrections officer's needs?

Mr. ANDERS. Let me clarify what the Bureau of Prisons guidelines require, and it will respond to your question, but I think it will also respond to what the other witness just testified. In terms of how the Bureau of Prisons guidelines work, the prophylactic treatment should begin immediately. Good medical advise right now is that treatment begins immediately. I don't know what goes on in all of the State systems, but in the Bureau of Prisons, that's what should happen if there is a significant risk of transmission. Also, if there is a significant risk of transmission, the medical officer is allowed to disclose to the physician for the corrections officer the HIV status if they have it on record for that inmate. They also can go to court and get a court order to have that inmate tested for HIV.

Mr. CHABOT. That may all be well and good, but that really wasn't the question I asked. The question I asked was it's the officers essentially here that want to have the inmate tested if they have some situation, as occurred in Ms. Wolfe's husband's case, and which you testified is that you're essentially concerned about the inmate being discriminated against if he is HIV positive or whatever. And it seems like we have a balancing that we have to—we have to make here. And it seems that you have balanced that in favor of the inmate's right to privacy as opposed to the health or perhaps the goodwill of the family and their peace of mind. Isn't that accurate to basically——

Mr. ANDERS. No, I don't think so. The Federal protocol is that, in an instance where there is a significant risk of HIV transmission, the guard's physician can go to the prison's medical officer and can get whatever the inmate's HIV status is if it is contained in the inmate's medical records. That's the standard right now under the Bureau of Prisons guidelines. That status can be disclosed. It can also—but the prophylactic treatment should already have begun at that point. But in terms of making a decision as to whether to continue the prophylactic treatment or to end it, if they need to get the inmate's HIV status, under the Bureau of Prisons

guidelines, they can go to court and ask for a court order to have that person tested. And that is the proper balance between the rights to know of the corrections officer as well as the privacy rights of the inmate.

Mr. CHABOT. Okay, I've run out of time. I ask unanimous consent for an additional 2 minutes, if that okay? Mrs. Wolfe, did you want to respond?

Ms. WOLFE. When we went through this, my husband was told if he goes and looks in an inmate's record or causes anybody to go look in an inmate's record for his HIV status, people would lose their job. People would go and the law would become involved. It would be major trouble. We were not allowed to find out his status, and no one was allowed tell us. They won't even let you know if there is a status on record.

Mr. CHABOT. And also what we're coming down to here is there are State procedures and there are Federal procedures, and they may be different. One final point or question with Mr. Parcell, Mr. Graney. Could you very briefly tell us how common it is these gasing attacks as was referred to on those tapes? Is that a pretty common thing that goes on?

Mr. PARCELL. It's somewhat common, sir. Let's see, before I transferred from the first prison I was at in 1997, we had several officers get doused with urine or some kind of liquid substance, and several of them came up with urine on them. That one officer—three times every—three times in a row—one, two, 3 days. And it's quite common if they come at—if they come at you. And it's not in—especially in the RHU—restricted housing units where the guys are in isolation, the hole, like the old movies. Especially there, if you open up a slot to feed them, and they'll throw something on you if pending whatever vendetta they have on you. It's somewhat common, yes.

Mr. CHABOT. Mr. Graney, did you want to?

Mr. GRANEY. Yes, in New York State we have 70,000—over 70,000 inmates and 21,000 correctional personnel. I would say I would get at least two or three phone calls a week dealing with exposure—be it blood or be it urine or feces.

Mr. CHABOT. Two or three a week?

Mr. GRANEY. Yes.

Mr. CHABOT. Okay, all right. Thank you very much.

Mr. GRANEY. And I may add one thing. We have gone to court and tried to get the disclosure on an inmate that exposed one of our officers, and we failed at court in New York State.

Ms. WOLFE. Lawyers won't even take your case that involves it because they know you can't win. We've tried five lawyers, and no one would take it.

Mr. CHABOT. I thank all the witnesses for their testimony, and now recognize Mr. Gekas for questions for 5 minutes.

Mr. GEKAS. I thank the Chair. Following up on this last little exchange, the—where Mr. Anders, is it?

Mr. ANDERS. Yes.

Mr. GEKAS.—stated that in certain cases, they could seek a court order to permit the testing. Is that correct?

Mr. ANDERS. Under the Federal Bureau of Prisons guidelines.

Mr. GEKAS. And that has presumed to be found constitutional?

Mr. ANDERS. I would have to get back to you on that.

Mr. GEKAS. Well, but you assert as part of your testimony that in these cases, they could seek a court order.

Mr. ANDERS. Yes, that's what the guidelines say. I don't know whether that's been litigated or not.

Mr. GEKAS. If the court can order it, then it would mean that the guidelines offered by this bill would simply side—advance that step once and allow the automatic mandated testing that the court would order anyway.

Mr. ANDERS. No, what courts have said is that inmates still have some rights in terms of what can be done to deprive an inmate of privacy and of where the regulations can go. There's a lot of deference that courts give to prison officials in terms of how they're going to manage the prison. But the deference only goes so far in that if there is no legitimate penological interest in a regulation, then the courts will not give deference to that particular regulation. So if there is no risk of transmission, there is no legitimate penological interest in obtaining that person's HIV status and turning it over to someone else.

Mr. GEKAS. But under your analysis, a court can make that determination, and if they find that it merits further analysis they could order the testing. Isn't that correct?

Mr. ANDERS. Well, that is a decision that a court can make.

Mr. GEKAS. And, therefore, we presume—don't we from the start—that that's constitutional?

Mr. ANDERS. Well, that again would be a decision that a court would have to make. But in terms of what's in the legislation, the vast majority of incidents that would be covered by this bill have absolutely no risk of exposure to HIV. So in terms of serving any kind of legitimate penological interest, there is no legitimate penological interest in having someone who has been spat upon to have the person who did the spitting tested for HIV. There have been no incidents ever of spitting resulting in the transmission of HIV. So in terms of legitimate——

Mr. GEKAS. You don't regard the mere act of spitting as a cause for a penological interest in that incident?

Mr. ANDERS. There may be other ways that the prison management should be responding to a spitting incident. Testing the person who does the spitting for HIV and turning that test result over to the person who was spat upon is not an appropriate response.

Mr. GEKAS. But you would—you not oppose a court order as to that. That's my point.

Mr. ANDERS. Oppose—I——

Mr. GEKAS. Because you stated that in a proper case that the court can order the testing. That's what you said.

Mr. ANDERS. Sir, sure in terms of if being able to make that argument to a court, but I don't know if you want to clog the courts with spitting incidents.

Mr. GEKAS. If it can prevent something, I think that the court order would be a good thing actually. One other question. You've made it sound very viable that, in your statement, that a corrections officer might not want to know at all for his own purposes he wouldn't want to know. I can't imagine a circumstance in which

the correction officer would not want to know. Are there any cases to that point that you know of?

Mr. ANDERS. Well, the protocol for treatment or for handling an incident like that is that the corrections officer is also given a baseline HIV test. This is under the Federal Bureau of Prisons and CDC guidelines. There is a lot of confusion, I think, going on here to some extent, because this is under the Federal guidelines versus what's happening in the 50 different States. In terms of what is the standard in the Federal prisons, the CDC guidelines and the Bureau of Prisons guidelines require a baseline HIV test. There may be guards out there who do not want the baseline HIV taken of their own blood when there is no transmission of HIV—or no possibility of transmission of HIV.

Mr. GEKAS. But, if they are—you mean to say that a corrections officer can make a determination when being splashed with some kind of bodily fluid, "Well that can't affect me. I won't have any chance of getting HIV, therefore, I'm not going to test myself or have myself tested." I can't imagine that that would occur. Maybe it does, but——

Mr. ANDERS. Well, frankly I am not sure that anyone is qualified to answer that question definitively on this panel, we don't any public health officials. We don't have any medical professional.

Mr. GEKAS. Yes. And so you are conjecturing, are you not, that a corrections officer might not want to—you're guessing, are you not?

Mr. ANDERS. Yes, I'm guessing that there may be corrections officers that don't——

Mr. GEKAS. Mr. Parcell, what part of Pennsylvania did you serve?

Mr. PARCELL. I'm around the northeast part, sir, around Bloomsburg.

Mr. GEKAS. Bloomsburg.

Mr. PARCELL. Below Wilkes-Barre.

Mr. GEKAS. I can tell you some stories about those areas. [Laughter.]

Mr. GEKAS. The—what I wanted to know was—were you given immediate time off when this incident occurred?

Mr. PARCELL. Yes. Yes, the procedure in Pennsylvania——

Mr. GEKAS. Yes.

Mr. PARCELL.—is if you, yourself, feel—and which 99 percent, as far as I know, 100 percent of the officers do. If you feel that there could be a problem, you fill out the appropriate paperwork, they'll send you right down on their time to get all the adequate tests. And then follow-up tests, if needed.

Mr. GEKAS. And one other—may I have an extension of time here?

Mr. CHABOT. Sure, without objection.

Mr. GEKAS. After the incident, did your fellow officers or your employers consider you an outcast of any sort?

Mr. PARCELL. Not at all. Not at all, we've—I've only—in that interim time there where I was waiting to be retested for the results to come back, I told two nurses—I needed to talk to somebody, two nurses and several of my fellow officers, and they were there. There is no doubt, we would have been there for anybody.

Mr. GEKAS. You heard Mr. Anders say the application of this law would create—could make a poria out of one whose——

Mr. PARCELL. That's a crock. [Laughter.]

Mr. CHABOT. Well, we'll substitute the word crock for——

Mr. PARCELL. I'm sorry, sir, I'm sorry.

Mr. GEKAS. That's all right.

Mr. CHABOT. It's a legal term we're quite familiar around here. [Laughter.]

Mr. GEKAS. Ms. Wolfe wants to answer that same question.

Ms. WOLFE. It happens to so many officers, the potential exposure.

Mr. GEKAS. Yes.

Ms. WOLFE. They're all accustomed to going through the fear.

Mr. GEKAS. The what?

Ms. WOLFE. They're all used to going through the fear because it happens to so many officers. Why would they make somebody a poria, when tomorrow it could be them.

Mr. GEKAS. I have no further questions.

Mr. CHABOT. Okay, I thank Mr. Gekas for his questions. And I want to thank the panel for very good testimony. And we'll take this under advisement and they'll be a road down the vote when we head into markup.

Thank you much. And with that, we're adjourned.

[Whereupon, at 11:30, the subcommittee adjourned.]

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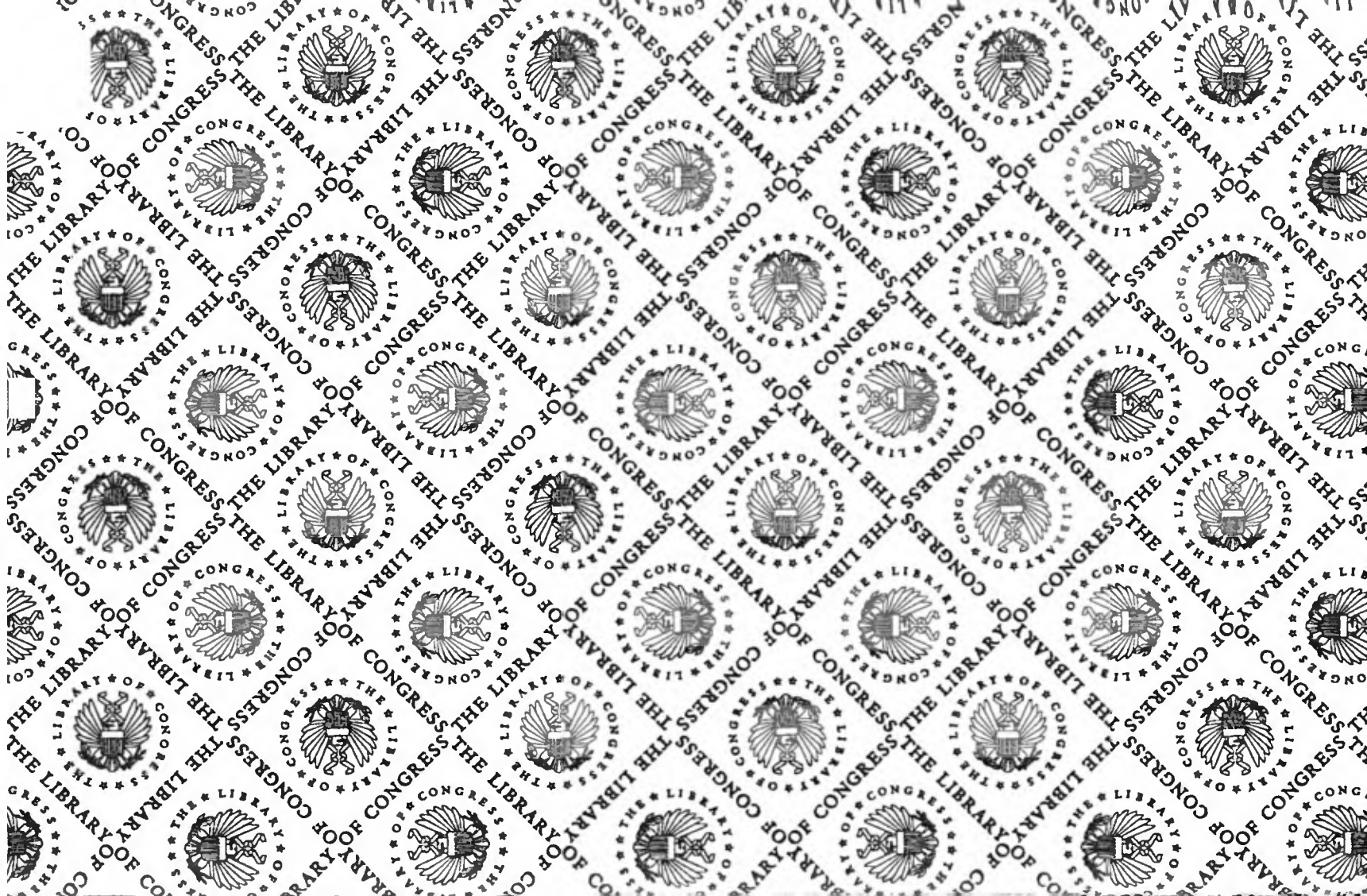
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